

## Retiree Health Plan Advisory Board Meeting Agenda

---

**Date:** Thursday September 9, 2021  
**Time:** 09:00 am – 12:00 am  
**Location:** Video Tele-Conference  
**Teleconference:** [Join meeting](#)  
**Audio Only:** (650) 479-3207 Access Code: 177 560 0912  
Password: Ngn6uUmUb26 (6466 8868 from phones)  
**Committee Members:** Judy Salo (chair), Lorne Bretz, Dallas Hargrave, Paula Harrison, Cammy Taylor, and G. Nanette Thompson

---

[OnlinePublicNotices](#)

- 9:00 am     **Call to Order – Judy Salo, Chair**
- Roll Call and Introductions
  - Approval of Agenda
  - Approval of May meeting minutes
  - Ethics Disclosure
- 9:05 am     **Public Comment**
- 9:15 am     **Review of comments received during Public Comment period**
- 10:00 am    **Discussion**
- Preventive Care
  - Specialty Medication Prior Authorizations
- 11:30 am    **Advisory Vote**
- 12:00 pm    **Adjourn**

Retiree Health Plan Advisory Board  
September 9, 2021  
Meeting Materials Table of Contents

---

Prior Meeting Minutes.....	3
May 13, 2021.....	3
August 5, 2021.....	19
August 19, 2021 (Subcommittee).....	40
Preventive Care.....	50
Executive Summary.....	50
Proposal.....	51
Attachments.....	69
Specialty Medication Prior Authorizations.....	113
Executive Summary.....	113
Proposal.....	114
Attachments.....	125

# Retiree Health Plan Advisory Board

## Board Meeting Minutes

Date: Thursday, May 13, 2021 9:00 a.m. to 2:30 p.m.

Location: Virtual meeting via teleconference and WebEx only

### Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Joelle Hall	Member	Present
Dallas Hargrave	Member	Present
Paula Harrison	Member	Absent
Nan Thompson	Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Ajay Desai	Director, Division of Retirement + Benefits	
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Mike Gamble	Member Liaison, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Christina Vasquez	Appeals Specialist, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Hali Duran	Aetna (medical third-party administrator)	
Daniel Dudley	Aetna (medical third-party administrator)	
Miranda Roberts	Aetna (medical third-party administrator)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Scott Young	Buck Consulting (contracted actuarial)	
Stephanie Gaffney	OptumRx (pharmacy third party administrator)	
Nicole Brown	OptumRx (pharmacy third party administrator)	
Dorne Hawxhurst	Public member	
Sue Nielsen	Public member	
Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)	
Wendy Woolf	Retired Public Employees of Alaska (RPEA)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	

## Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MA = Medicare Advantage, a type of Medicare plan available in many states
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post-Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits, and the retiree health trust
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

## Meeting Minutes

### Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m. A quorum was present.

#### Approval of Meeting Agenda

*Materials: Agenda packet for 5/13/21 RHPAB Meeting*

- **Motion** by Cammy Taylor to approve the agenda as presented. **Second** by Nan Thompson.
  - **Discussion:** None.
  - **Result:** No objection to approval of agenda as presented. Agenda is approved.

#### Approval of Previous Meetings' Minutes

*Materials: Draft minutes from the 2/4/21 RHPAB Meeting.*

- **Motion** by Cammy Taylor to approve the 2/4/21 meeting minutes. **Second** by Nan Thompson.
  - **Discussion:** None
  - **Result:** No objection to approval of minutes. Minutes are approved.

#### Ethics Disclosure

Chair Salo requested that Board members state any ethics disclosures in the meeting and reminded members of the disclosure form available from staff, to keep any necessary disclosures on file.

- No disclosures were stated by members.

### Item 2. Public Comment

Before beginning public comment, the Board established who was present on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that if there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Chair Salo also reminded Board members and members of the public of the following:

- 1) A retiree health benefit member's retirement benefit information is confidential by state law.
- 2) A person's health information is protected by HIPAA.
- 3) Testimony will be posted on the Board's website and will be publicly available, including both written comments and statements made verbally in meetings and recorded in the minutes.
- 4) By giving public testimony on those subjects, the person will be treated as having waived their right to confidentiality regarding the subject of their testimony.
- 5) An individual cannot waive this right on behalf of another individual, including spouse or family member.
- 6) The chair would stop testimony if any individual shares protected health information.

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: [rhpab@alaska.gov](mailto:rhpab@alaska.gov).

#### Public Comments

- No one in present in the meeting wished to testify during this period.

### Item 3. Department of Administration + Division of Retirement & Benefits Updates

Chair Salo asked Emily Ricci to share updates.

#### Staff Update

Emily introduced Division staff present in the meeting. Staff are following the State's guidance and are working on returning to work in the office. Currently most staff are working from home. Within the next two weeks, staff will shift to a hybrid telework / office work model, and eventually work toward opening the office to the public again. Staff will advise when members can physically go to the office for assistance. In the meantime, the staffing will shift, but the office remains closed to the public.

#### Retiree Plan Reporting

*Materials: Presentation beginning page 20 in 5/13/21 meeting packet*

Staff have been working on a dashboard to measure and report out the AlaskaCare plans' performance, including eligibility, financial performance, and total spend.

The report provided (page 20 of packet) illustrates the number of current members, as well as projected enrollment based on employees' eligibility to retire and vested point. The projections are estimates because some employees may be retirement age but not necessarily fully vest. There is also a recent court ruling (*Metcalfe*) that changed members' ability to access the defined benefit plan who had already "bought out." Before they were not eligible; this complicates the projections, as it means that people are eligible to re-enter the plan. This applies to Tier 1, 2 and 3 employees/potential retirees.

There continues to be a strong shift of retiree members becoming Medicare eligible (turning 65), showing a large cohort of retirees who become enrolled in Medicare. This shift is relevant when thinking about proposals like offering preventive care (to be discussed today). The rate of new enrollments under 65 is also generally decreasing, meaning relatively fewer people under 65 are entering the system.

- Judy Salo asked for a brief summary of the case ruling, and what the Division expects to see as a result of this decision?
  - Ajay Desai responded that the case was focused on employees who withdrew from employment and "bought out" (received benefits in a lump sum), which meant previously that they would lose benefits even if they were vested. At the time, they would be ineligible once they withdrew, and could not "buy back" this service. The court ruling changed this and made it possible for any former employee to "buy back" meaning they can participate again by paying the lump sum plus interest. For example, if they are required to pay \$20,000 (sum + interest), they could be spending a great deal of money with limited benefit (such as about \$100 per month). This also increases administrative staff time to address these questions.

The Division is working to prepare information to educate members about their options, and to help people make an informed decision about whether to participate in this.
- Judy asked if this ruling applies to PERS retirees only, or others such as TRS and JRS?
  - Ajay will follow up. [*Answered at end of meeting: this is all defined benefit groups*].
- Judy asked how many people this impacts?
  - Emily responded this potentially impacts up to 87,000 people, anyone who previously took benefits with them and at the time forfeited their access to the benefits. This certainly impacts the projected number of members who will participate in the plan.

- Judy commented that as a board member, she would not feel comfortable providing more detailed information to members. She recommended, and will recommend to anyone who asks her, calling the Division to understand the impact and what (potential) members' options are.
  - Emily agreed this is a good approach. She noted that the Pension staff are taking the lead on this issue and preparing materials, including an FAQ. Division staff will share this information with board members when it's available.

## COVID-19 Updates

*Materials: Presentation beginning page 21 in 5/13/21 meeting packet*

Emily Ricci invited Daniel Dudley from Aetna to present highlights from what was presented in the quarterly vendor meeting, specifically about impacts of COVID-19 on the plan.

Daniel presented: these numbers (page 21) relate primarily to the under-65 (not Medicare eligible) retirees, for whom the plan is the primary payer. There was only about a 1.3% decrease in utilization, which is consistent across Aetna's book of business (West Coast public sector plans). This is a smaller decrease overall across the year; however, there was a significant decrease in utilization early in the pandemic (March-May 2020). For the rest of the year, beginning in June 2020, utilization returned to much closer to "normal" (the 2019 numbers) month to month. This was a positive trend, reflecting that members responded to the health recommendations and stopped accessing non-emergency care, but then returned to accessing care as needed when it was safer to do so. This still resulted in a 9.1% decrease in per member per month spending, because of the decreased utilization in the spring, but this was not as low as it might have been if that trend continued longer.

He noted that the plan took many proactive steps to expand or change benefits to serve members, including coverage of certain vaccines and primary care; expand telemedicine coverage; and allowed a higher cost share (100% to the plan, not the member). This allowed members to still access services, including their existing providers who previously did not bill for telemedicine. As a result, there was a massive increase in telemedicine utilization, over 22,000% over the prior year. The Alaska plans' expansion of this benefit was extremely beneficial for members and minimized impacts on access to services for members.

The utilization graph indicates that several services were utilized less: inpatient surgery, outpatient procedures, emergency room visits, and primary/specialty care visits. There was an increase in behavioral health services from the prior year.

- Cammy Taylor asked about the difference between utilization versus spending.
  - Daniel noted that utilization and spending were both down, but this suggested that people were utilizing less high-cost services. This also could be explained by fewer people having serious health incidents or care for conditions.
- Cammy asked whether this meant people were not getting needed care?
  - Daniel responded that there was not a significant decrease in serious health incidents (heart attacks, etc.) so he does not see the decrease as reflecting that people were not getting needed care. This is consistent across other plans as well.
  - Emily added that utilization is for all services, and does not reflect the severity, complexity or cost of those services. This simply suggests that there were relatively more lower-cost services, via telemedicine or perhaps putting off elective procedures.

- Daniel commented that elective surgeries were certainly delayed by several months, and some were put out further.
- Emily added that there could still be a significant amount of pent-up demand for services, that will result in a higher utilization of services as people catch up on non-emergency care needs, but this is speculation. There may not be a significant increase or cost to the plan beyond normal trends, it's hard to say.

Daniel continued: page 22 gives more detailed data about how COVID-19 related claims impacted the plan, with a total of 15 months of data to date (Mar 2020 – May 2021). Aetna estimated about \$6.9 million was spent on COVID-related claims, which was about 1.6% of total spend during this period, for both the employee and retiree populations together. This impacted approximately 22,485 members (covered lives) enrolled in the plan. Based on prior conditions, Aetna estimated that almost ¾ of plan members were in the high-risk category, with the remaining 25% in the general risk category.

Aetna's claims data includes any information about COVID tests, treatments and vaccinations—this might be missing some data, such as vaccines not billed to the plan. Based on the data, there were approximately 2,200 members with confirmed cases, another 27 probable cases, and over 10,000 probable exposures. There were also about 10,000 lab tests, screenings and vaccinations only.

The plan paid a total of \$2 million for testing, about 25,000 tests—most tests were viral tests, with a smaller number (2,685) antibody tests. The plan has paid a total of \$105,646 to date (of the vaccinations submitted to Aetna) for vaccination, which was about 4,276 members receiving at least one dose and 2,434 being fully vaccinated. This does not include a probably large number of people who were vaccinated but the plan wasn't billed, and any claims submitted via the pharmacy plan, which Aetna does not administer. He assumes that the total number vaccinated is much higher, based on other data about Alaska (and other states') vaccine rates.

Page 23 includes more detailed information about estimated claimants who had a confirmed or probable COVID-19 diagnosis. Daniel noted that Alaska's plan numbers are lower than average across other plans, especially notable given the number of members enrolled, so the plan performed well and had relatively fewer cases and less impact than the experience of many other group health plans.

Page 24 further provides information on testing and vaccination, including by age cohort. The charts include information about which vaccines people received, vaccination rates by population (employee, retiree, spouses and dependents), and vaccination rate among high-risk and general-risk populations.

Daniel concluded that the vaccines were only available starting December 2020, and many people are still in process of accessing vaccines and getting both doses. He anticipates that the vaccination rates will go up, whether the claims are reported to Aetna or outside their data, and optimistic these positive trends will continue.

Emily also shared that the Division provided an e-mail and postcard mailing update to members last week (Thursday, May 6) and informed members about which temporary benefits are remaining in place, being ended or adjusted now that we are moving out of the COVID-19 pandemic's primary phase. Some benefits will not continue, but some are being extended at least temporarily, such as the flu and pneumonia vaccines being covered through December 31, 2021. The intent for this temporary coverage is that beginning in 2022, these services will be covered through the proposed expanded coverage of preventive benefits for retirees.



The other benefit being extended is Teladoc for retirees at a \$0 co-pay through June 30, 2021. This benefit is only cost-effective for the Division if 1) members are using the benefits, and 2) if higher-cost services are avoided by people being served through telemedicine. The fixed costs for this service make it costly if it is not being widely utilized and impacting other care choices. Currently there is no long-term strategy to offer this service for retiree members, given the administrative costs at this time; if the benefit is extended further, the \$0 co-pay would also need to be added to the plan booklet, which would constitute an added benefit to the plan. Coverage for the COVID-19 tests and vaccines were also permanently added to the plan as a new benefit.

- Cammy Taylor asked to clarify the difference between Teladoc and telemedicine services?
  - Emily responded Teladoc is a specific company and service provided, using their platform and with specific services included. Telemedicine generally is a method of service delivery, which can be done by a variety of providers and simply means that care is provided via electronic means (phone, text, video call, etc.) instead of a traditional in-person visit. The Division intends to cover telemedicine going forward but is reviewing other employers' coverage for these services will be and being clear about what is covered and how. They will be preparing a presentation for the board and discussing at a future meeting, after determining what specific policy and coverage terms they will continue to offer retirees. Only the specific Teladoc service will be ended on June 30: for example, only 90 members utilized the service in March 2021, compared with over 70,000 members in the retiree plan in total, so currently it is not cost effective.

#### Long-Term Care Contract

*Materials: (none)*

Emily invited Betsy Wood to share an update: Betsy shared that the long-term care vendor contract was put out for competitive bid this past year, consistent with how they handle third party administration for health plans. The proposal evaluation committee met, including board member Cammy Taylor, and selected a vendor. A notice of intent to award was released on April 30, and following the protest period, they are negotiating the new contract to begin July 1, 2021. CHCS Inc., the current vendor, was the successful vendor.

Members should not expect any interruptions or disruptions of service when the new contract takes place, but there will be some changes to the contract starting July 1, enhancing and improving services for members. There will not be a change to actual benefits or coverage, but members will be able to access a new online portal to see their account and access documents; CHCS will accept claims electronically, not just on paper; and some back-end operational improvements for working with Division staff and HCHS including transmitting information. Additionally, members will be able to receive electronic fund transfers (ETF) for reimbursements, not just paper checks: this is something members have asked for.

#### EGWP Projections Update

*Materials: Presentation beginning page 28 in 5/13/21 meeting packet*

Emily invited Richard Ward to present. Richard shared an overview of the table on page 28: as projected, most of the subsidies the state receives continues to increase over 2019. The only significant decrease was to the Direct Subsidy, which is a formula-based subsidy that tracks with the costs in the individual market. This has been declining for all plans because of the way the formula works. However,

other subsidies continue to increase, including the Coverage Gap Discount (from drug manufacturers, based on the number of gap “donut hole” claims) and Catastrophic Reinsurance. The income-based premium and cost-share subsidies typically would go to members who are paying premiums, but since few members pay premiums in this plan, those savings go back to the plan directly. Overall, there were a total of \$49.5 million in subsidies in 2019; an increase to \$58.4 million in 2020; and a projected modest increase in 2021, for a total of \$62.3 million. This represents an increased value of adopting the EGWP over time, as the plan receives offsets for pharmacy costs via federal subsidies.

#### **Item 4. Modernization Initiatives**

*Materials: Presentation beginning page 29 in 5/13/21 meeting packet*

##### **Preventive Care**

Emily provided context: The Division has made some recent changes to the plan, such as expanding coverage for vaccinations, but has also discussed (including with this board) proposals to change benefits in the retiree plan. There has been interest from members to expand benefits, such as preventive services, but any changes to the plan need to take into consideration financial impacts, and potential offsets for expanded benefits. She also noted that as the number of members who are eligible for and enrolled in Medicare continues to increase rapidly, and the adoption of the EGWP pharmacy plan has also positively impacted the plan’s financial health.

While the group has in the past discussed a large packet of changes, including expansions and offsets, this path is extremely complicated and may not be feasible to do at this time. However, Division staff did not want to lose momentum or the opportunity to provide value to members—one of these is covering preventive care, which would primarily impact members who are not eligible for Medicare. While the discussions have characterized expanded benefits as needing an offset to reduce financial burden on the plan, the Division is proposing to expand preventive benefits without an offset.

The “offset” this proposal offers, across the entire plan, is potentially a long-term reduction in the need for pharmacy utilization. The Division will also continue discussing options for managing pharmacy plan costs with the board. The plan saw a 21% in pharmacy costs between 2019 and 2020: this is due to several changes, including more specialty drugs and other market factors; gene therapies (which can cost multiple millions for a single treatment); and other factors, such as population health. This trend will continue as the landscape changes, and necessitates thinking about managing costs, especially pharmacy costs. The Division will continue that discussion in board subcommittee meetings.

Emily offered that Division staff would like to introduce the proposal today for discussion; to schedule subcommittee meetings for further work on this proposal; and to determine when the board would entertain a formal advisory recommendation vote at a future meeting.

Emily invited Betsy to present: Betsy shared that the board has seen this proposal before (prior to some members having joined the board), but the Division has made some updates and will provide an overview of the current proposal. Because the original retiree plan was created in the 1970s, it reflected how health plans were structured at the time: it primarily covers diagnosis and treatment for injury or disease. It does include very limited services, like prostate cancer screenings, but does not include many of the preventive or primary care services that are now standard in commercial health plans. As a result, the plan does not reflect what is commonly considered core health services, especially preventive

screenings and other services that are designed to help keep someone healthy and reduce risk of future disease.

This proposal will primarily benefit members who are not Medicare eligible, because when they are enrolled in Medicare, that plan is primary coverage and already includes these benefits. This includes retirees who are under 65, but also spouses and dependents, which may include young children or younger adults who would not be covered.

Betsy also clarified that because the plan is retirees only (although it does allow for enrollment of other people, it is designed to be for Alaska retirees), the plan is not subject to the provisions of the Affordable Care Act, which requires health plans to cover preventive services—it is exempt. However, the plan can choose to cover these services, which is why this is being proposed.

Page 30 includes an overview, and outlines the Division’s objectives for this proposal:

1. Support members in maintaining their health.
2. Promote high-value care.
3. Increase accessibility to patient care for non-emergency health episodes.

Page 31 has a more detailed summary of what would be included: the proposal is to add all evidence-based preventive services covered in most commercial plans, and consistent with the Affordable Care Act. This is defined as services with an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF); standard vaccines recommend by the Advisory Committee on Immunization Practices (ACIP); preventive care for children recommended by the American Academy of Pediatrics; and specific preventive services for women, also recommended by the USPSTF. The goal is to cover evidence-based services the way they are covered in other plans.

*The Board took a 15-minute break at 10:33 a.m., and returned to the meeting at 10:45 a.m.*

#### Preventive Care, continued

Judy called the meeting back to order.

- Judy asked whether the organizations listed as having evidence-based practices are trustworthy and whose recommendations or guidance can be followed for the long term?
  - Emily responded these are the organizations designated by the federal government to determine standards for coverage of preventive care services across plans in the U.S. They are recognized in the Affordable Care Act as the standard. She also noted that staff looked at the coverage in the employee plan, which is ACA-compliant and follows industry standards, and that these are “mainstream” recommendations. This would also minimize differences between the employee and retiree plan, for members who transition from one to the other. It also benefits the third-party administrator in dealing with claims, to not have to manage two different types of coverage for these services.

Betsy continued the presentation: she shared that there are multiple options, for the board to provide feedback, regarding cost-share for members for these services:

**Option A:** This was the first one presented to the board when originally discussed. For in-network care, members would pay their \$150 deductible, at which point the plan covers services at 80% until the member’s out of pocket expenses are met, when the plan would cover 100%. This is the same cost share

for most other services in the plan. If the provider is out of network, the plan would have the same \$150 deductible, then would be covered at 60% of the recognized charge (and member could be balance-billed). There is no out of pocket maximum for out of network charges, and the plan would continue to pay at 60% through the year. If there are no network providers in the member's area, they would contact the administrator (Aetna) for precertification to be covered as in-network services. This is intended to control plan costs by incentivizing in-network care, since this would be a new benefit.

**Option B:** Similar to Option A, but in-network preventive services would be covered at 100% from the beginning, with no deductible and no coinsurance. This is more similar to the employee plan and ACA-compliant plans cover these services, if in network. However, if a person receives services from an out-of-network provider, the coverage would be similar to Option A: the member would meet the \$150 deductible, then the plan would pay 80% of services, with no out of pocket maximum for these services. And same as Option A, if there are no in-network providers in the member's area, they can receive precertification from Aetna to be covered as if it was in network. Again, this would be up to the recognized charge, so the member could be balance billed, but the coverage would be the same as for in-network providers.

Emily added that the proposals were designed to provide benefit to members; incentivize network participation, which benefits the plan and the member; but also provide an exception for members who have limited options for care, and cannot find an in-network provider, so they aren't penalized. She shared that staff have an initial preference for Option B, as this more closely aligns with the employee plan and most other commercial plans but wanted to present both for discussion.

- Cammy asked which option aligns more closely to Medicare coverage for those who are Medicare eligible?
  - Betsy responded Medicare covers most of these preventive services at 100% but depends on whether the service is a screening (preventive only) versus a diagnosis (then covered as a service, along with any procedure to address this). Example: if a colonoscopy result shows no issue, it would be covered as preventive. If something is detected, it would be diagnostic.
- Judy Salo asked how coordination of benefits would work?
  - Betsy responded the plans would coordinate in the same way they did today, with Medicare being primary and probably covering these services. For those who have coordinated benefits and aren't on Medicare, the plans would coordinate, and likely would cover (at least under Option B) 100% and likely not involve the other plans if AlaskaCare is primary. If AlaskaCare is secondary, this would cover anything that the primary plan doesn't cover, if it doesn't cover those services at 100% already.

Tables 1 and 2 (pages 32-36) illustrate how both options compare to the current plan. Specifically, there are some services (mammogram and pap smears for women, prostate screening for men, and several other services outlined in Table 2) that would also change the plan's coverage from what is currently in the plan, based on Aetna's policies. Aetna has its own clinical policy bulletins re: coverage, that goes beyond what's in the national recommendations, particularly for people at higher risk. Where those guidelines differ from the evidence-based guidelines below, the plan will follow those standards and can be updated because it is based on the most current information and guidance. And, if a screening results in a diagnosis, it is considered diagnostic, and would be covered differently than a simply preventive screening. This can be discussed further with the board or modernization committee, and Aetna can

speaking further to what goes into the decision for their own guidelines, they use additional clinical information to make those determinations.

Emily added that one example of the changing guidelines is Pap smears to screen for HPV: especially for younger women, it is common to have a positive result but which the body takes care of naturally over time, so a less frequent screening is warranted. The cost of treatment or the risks of having the test done (unnecessary procedures that do not add value, or actually harm) is also taken into account. Mammograms are also now not recommended for younger women unless they are high risk, because their breast tissue may be denser and make a false positive more likely. The goal is to not have unnecessarily frequent screenings. There are also considerations such as those for colon cancer: younger people (in their 30s and 40s) are being diagnosed, so it is beneficial to do these screenings easier to catch it sooner and be able to treat that cancer. Population health trends change, as well as clinical understanding or evidence for these screenings. The proposal would also expand a variety of cancer screenings, beyond the three listed above, which is often requested by members due to the cost of those tests. Being able to pay for those screenings and catching any cancers early will improve chances of survival and recovery and would benefit members as well.

The proposal would also allow for annual physical exams, and well child and well woman visits each year. This is relevant for dependents such as children, who are in most circumstances not eligible for Medicare, but who may be enrolled in the plan. This would benefit younger enrolled members.

Betsy noted that currently coverage of vaccines is a pharmacy benefit only. Emily added that this would expand coverage for those vaccines beyond what is covered now, because it would allow coverage of those services at a doctor's office and not just a pharmacy.

The analysis of impacts beginning on page 36 is summarized as follows:

- Actuarial Impact | Increase by 0.45% to 0.50% (plan's actuarial value)
- Financial Impact | Annual Cost Increase by \$3m to \$3.35m
- Member Impact | Enhancement, expands benefits that are not covered today
- Operational Impact (DRB) | Neutral, will not significantly change administrative workload
- Operational Impact (TPA) | Moderate, requires change to Aetna coverage and plan policies

Betsy noted that a comparison between preventive visits/services (mostly screenings for women) in the retiree versus employee plan illustrates the importance of coverage: there is great utilization of preventive services across all age ranges for employees, but very little utilization by retirees.

- Cammy commented that she has questions, but that discussion about specific coverage options would be best done at the modernization committee, to be able to dive in at greater depth.

Betsy continued, summarizing the impacts to the plan (detailed in the materials).

**Actuarial:** This would slightly increase the actuarial value of the plan, meaning the plan will pay somewhat more of members' yearly health care costs on average. Both options represent a modest increase, with Option B slightly more (0.50% versus 0.45%).

Richard noted that the plan change would primarily benefit people not enrolled in Medicare, but that all the impacts are calculated in aggregate across the whole plan—so, this would benefit a subset of members, mostly those who are not enrolled in Medicare.

Emily reiterated that at this time, the Division is not looking for a specific offset for this plan change: this would slightly increase the value of that plan and will have potentially many other benefits for members and for effective management of plan costs, and this would not be implemented with a specific offset.

- Cammy asked for clarification that this would essentially only benefit non-Medicare members.
  - Richard responded yes, much of this is already covered by Medicare.
- Judy commented that it makes sense to not consider a specific offset: not only is the number of non-Medicare eligible members going down as people age into Medicare, and there is a slow of new people enrolling in the defined benefit retiree plan, but also ideally coverage of preventive services and screenings will have other downstream cost avoidance if people remain healthier and/or their conditions are caught earlier.
  - Richard agreed, and noted that not only is the number of people not Medicare eligible are shrinking, but the rate at which they are entering the plan or eligible to enter the plan is shrinking. As people retire later, they will be in this category for a shorter period of time, which also limits potential financial impacts to the plan. Retirees used to enter the plan at an earlier age, but that is trending older now. This is a trend not just in Alaska, but many health care plans.
  - Betsy reminded the group that families covered under the plan, which may include several household members who are not Medicare eligible, this will also significantly benefit those member households in terms of what's covered.

Betsy continued:

**Financial:** The proposal anticipates some increase to the plan (about \$3 to \$3.5 million in 2022), but they also anticipate that there will be some long-term savings or avoided cost over time. Some of this will also accrue to Medicare rather than the AlaskaCare plan, as people's avoided health care costs over time will include people who are enrolled in Medicare. This estimated cost does not factor in long-term savings or cost avoidance, or potential cost in future years. It simply estimates cost during implementation in the first year, and how it will be reflected in the 2022 plan year.

Emily added that, for example, colonoscopies are expensive, which is why in-network services are important: it would be one of the biggest cost drivers for this proposal, but also is one of the biggest costs to members and therefore a disincentive for members to seek this service and pay out of pocket.

Long-term impacts were analyzed by Buck Consulting; Betsy asked Scott Young to present their findings after sharing an overview:

The Buck team previously conducted a valuation of the plan in June 2020; they were asked to also determine what impacts this would be long-term to that 2020 valuation. The findings did estimate an increase to the valuation of the plan, both Actuarial Accrued Liability (AAL) and Additional State Contributions (ASC), but also does not reflect the stronger position of the retiree health trust currently. Both options show an increase over time, with the total value of liability increasing (the net present value for resources needed to cover all anticipated future costs). However, given that the plan is currently overfunded, meaning that it has enough (or more) value to cover all projected costs at this time. This position can change, but is currently a positive position to be in. Therefore, the projected long-term impact does not apply as it would have in the June 2020 valuation. If the plan were not overfunded, the state's required assistance payment would be \$2.0m (Option A) or \$2.3m (Option B), or an actual payment of \$400,000 in a given year.

- Betsy asked Scott to clarify: would this impact the overfunding of the health trust by adopting this plan change, or would it still be overfunded?
  - Scott clarified that the plan would still be overfunded, just by a smaller degree, but this would not have a significant impact.
  - Emily reminded the group that the health trust is also dependent on the performance of the stock market and investments that are included in it; market volatility would also impact the fund's performance, such as a significant drop in value. Those are issues for the fund's managers to deal with and are external to the health plan's design or management but are still important to keep in mind as factors that impact the health of the fund generally.
  - Scott noted that a significant increase in membership, such as the result of the court decision about new members buying back into the plan, would also impact the plan.
  - Emily reiterated the importance of the plan actively managing costs to the degree possible, because the health trust is also impacted by external factors such as enrollment numbers, people's overall health needs and utilization, and the financial performance and management of the plan.

Betsy continued:

**Members:** This is definitely an enhancement for members, not just for covering additional preventive services and helping maintain health, but also lessening the disruption or confusion when transitioning from the employee plan (which covers these already) to the retiree plan.

**Operational Impact (DRB):** The impact is listed as neutral for the long term but will have short-term impacts on staff. It would require changing the plan booklet, including the public comment and meeting process to educate members on the proposed language changes and adopting the changes. The impacts of this change will generally be positive for members, as they have asked for this coverage, but would also take staff time and process changes to implement. This includes making changes to codes and coverage, and testing that those are working correctly, so that claims are processed accurately.

*The Board took a break at noon, and returned to the meeting at 1:15 p.m.*

Chair Salo welcomed the group back to the meeting. She was also available in the meeting at 1:00 p.m., to inform anyone who arrives for afternoon public comment that the meeting was delayed to 1:15 p.m.

**Item 5. Public Comment, Continued**

Chair Salo reiterated the public comment guidelines and invited the public to provide comment.

Public Comments

- No one present in the meeting wished to provide comments.

**Item 6. Modernization Initiatives, continued**

*Materials: Presentation beginning page 29 in 5/13/21 meeting packet*

Judy invited Betsy to continue her presentation:

## Preventive Care

**Operational Impact (TPA):** This would have a moderate impact to the administrator (Aetna) for the implementation period, to update policies and make a shift toward how claims will be covered. However, longer term it may be less burdensome for Aetna, as they do not have to manage two separate sets of benefits between the employee and retiree plans.

**Clinical:** Overall, this will generally benefit health outcomes for members, because it will incentivize members to seek primary and preventive care, screen for serious conditions such as cancer so they can be caught and treated early, and generally encourage members to proactively manage their health.

**Provider:** Overall, this will also benefit providers. More services will be covered by the plan and members will be able to access and pay for services more easily. This may include a provider seeing more AlaskaCare member patients and increasing their customers; being able to bill and be reimbursed for services they provide; and, with the network provisions, a clear incentive to become an in-network provider to receive a higher reimbursement and make their services more attractive for members. Some providers, such as those in Juneau, have inquired about the retiree plan covering these services. Because the co-insurance coverage is higher for in-network, it may also incentivize providers to become network providers rather than attempting to balance bill members.

Emily concluded by reiterating that in order to manage costs in the plan long term, it is essential to promote members managing their health and utilizing routine care to the extent possible, to avoid costly emergency or other care later, which also potentially improves quality of life.

- Judy expressed some concerns about the network provisions proposed, to make sure that members have options if they have no or limited in-network choices. She noted that many people, particularly in rural areas, travel for care—how would this impact network decisions? Would the travel benefits be changed as well? Can we be clear that the plan will not cover travel for routine care, but to help members find in-network providers in Anchorage or other larger communities where people travel?
  - Emily agreed, and noted that expanding travel benefits generally would be significant and is not being proposed at this time without further consideration of offsets. She agreed that it may be appropriate to consider coverage of some specific services, such as colonoscopies, and this merits further discussion. But at this time, the proposal does not include changes to travel benefits, beyond what is already available to retirees.
- Judy asked what other proposals, if any, are being considered as well?
  - Emily responded staff have also discussed removing the lifetime maximum in the plan, which currently impacts a limited number of people, but would have an immediate positive impact for those members. Staff are still determining what the actual impacts to the plan this would be, and if it is feasible without requiring an additional offset or other cost management consideration, given that it would remove a limit on coverage that exists now.
- Cammy asked about the travel coverage: currently, if a service is not available in their area, there is limited reimbursement (air fare only) for retirees. Could this be factored into the costs for members, particularly if it is cheaper even with travel costs, and/or that service is not available in their community?



- Emily noted that currently retiree travel is only covered for treatment services, not preventive services, so this is limited coverage. However, this can be discussed at the modernization committee as a possibility.
- Judy suggested language such as “travel to nearest network provider” for coverage, which can still provide an incentive to seek out a network provider and help with cost controls in the plan generally.
- Betsy suggested this proposal is worth considering further, and that discussion continue at a modernization committee meeting, where more details can be considered.

The group concluded the presentation and discussed next steps.

Emily shared that the next board meeting is early August, and ideally there could be at least two subcommittee meetings to further discuss and make recommendations about this proposal, coming back to the board for a formal recommendation at its August (or later) meeting.

- Nan Thompson asked about the overall plan: in prior discussions, the group considered a number of proposals and how to address offsets. Now, the Division is proposing this one change, which she appreciates and supports, but that it is an overall shift in the process and method to consider changes. What is the Division’s rationale for changing the approach?
  - Emily noted there are several considerations that happened over the last two years, including: the creation of RHPAB as a board, and the discussions with this group; the financial position of the health trust improving, and being overfunded; the adoption of EGWP, which significantly impacted costs in a positive way; and other steps taken to address the long-term financial health of the plan. Additionally, there is ongoing active litigation now about the health plan, which could substantially impact the plan’s financial outlook depending on the outcomes.  
Given the impacts of these changes, and the fact that it has been 3 years since the discussion began, the Division was interested in being able to take some actions now for the benefit of members, rather than continuing to wait. It seems more feasible to consider smaller changes, particularly those with clear benefits and limited costs, and begin to implement these where they are feasible. The Division is still interested in considering a larger package of changes, but to not let that longer timeline prevent some changes from happening now. Staff and retirees are very interested in having preventive services covered, and this seems feasible, so it is an opportunity to make some change now, while continuing to work on the larger discussion. This is a shift from the Division’s past positions, but generally the Division is still focused on how to improve the plan for members while balancing the financial stability of the plan long term.
- Judy commented that the discussions at the modernization committee certainly showed that there are no “easy” or obvious changes, and it is not easy to find 1:1 equivalent enhancements and offsets, but that plan changes are complicated.

The group discussed scheduling:

Staff recommend at least two modernization committee meetings to review the preventive services proposal. Staff would also like to keep working with the board on some other specific issues: changes to the pharmacy plan to add preauthorization for certain high-cost medications to ensure the medication is necessary and appropriate before being filled; and other potential cost controls to manage cost

increases (such as the 21% increase in one year!) without having to change benefits or impact access to needed medications by members.

Cammy agreed that having multiple modernization committee meetings would be useful, and to focus on the preventive care proposal but also begin discussion of other items. The group will work on scheduling meetings in the next few months.

Judy invited all board members to attend the committee meetings, which have a subset of the board as members but are welcome to all (they are also public meetings, like the board meetings).

Nan Thompson indicated she is willing to attend meetings depending on the schedule.

Board members will respond to the Division's scheduling requests with their availability, and the meetings will be noticed when the schedule is set.

## Item 7. Closing Thoughts + Meeting Adjournment

### Closing Thoughts

Judy invited any final comments from board members; no comments.

Ajay provided updated information about which retiree groups are impacted by the *Metcalfe* court decision discussed early in the meeting: this does include all defined benefit retirees, including PERS, TRS and other groups who qualify for this plan.

Emily noted that at the August board meeting will include an update on how the Division is working to comply with recent federal legislation regarding transparency and cost reporting. Some of the law changes do not necessarily apply to the retiree plan (retiree-only plans are exempt), but they are working to comply with needed changes, and also address issues such as balance billing. The federal guidance is anticipated to arrive in June or July, so they will make updates when available.

Judy suggested having a standing agenda item for law, regulatory and legal changes: this can include law changes, regulatory changes, and any issues related to litigation. Board members are likely not tracking these closely, so having an ongoing update on anything the board needs to know would be helpful.

Judy thanked Division staff for their hard work, preparing for the meeting and everything else they are working on. She thanked board members for attending and participating in this effort as well.

### 2021 Board Meetings

The board's quarterly meetings are scheduled as follows for the remainder of 2021. Meetings will be held virtually for the foreseeable future. For each date, quarterly vendor meetings will be held the day before (Wednesday).

- Thursday, August 5, 2021
- Thursday, November 4, 2021
- **Motion** by Nan Thompson to adjourn the meeting. **Second** by Lorne Bretz.
  - **Result:** No objection to adjournment. The meeting was adjourned at 1:52 p.m.

---

### The next Retiree Health Plan Advisory Board meeting will be Thursday, August 5, 2021.

Check RHPAB's web page closer to the meeting to confirm the schedule, location and to download materials for upcoming meetings. <http://doa.alaska.gov/dr/alkacare/retiree/advisory.html>.

# Retiree Health Plan Advisory Board

## Board Meeting Minutes

Date: Thursday, August 5, 2021, 9:00 a.m. to 3:00 p.m.

Location: Atwood Conference Room, Anchorage; State Office Conference Room, Juneau; WebEx (virtual)

### Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB) Members</i>		
Judy Salo	Chair	Present
Cammy Taylor	Vice Chair	Present
Lorne Bretz	Member	Present
Joelle Hall	Member	Absent
Dallas Hargrave	Member	Absent
Paula Harrison	Member	Present
Nan Thompson	Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Emily Ricci	Chief Health Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Erika Burkhouse	Assistant Vendor Manager, Retirement + Benefits	
Mike Gamble	Member Liaison, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Kevin Dilg	Alaska Department of Law	
Hali Duran	Aetna (medical third-party administrator)	
David Broome	Aetna (medical third-party administrator)	
Dr. Lydia Bartholomew	Aetna (medical third-party administrator)	
Blythe Keller	Aetna (medical third-party administrator)	
Andrew Robison	Aetna (medical third-party administrator)	
Carrie Sather	OptumRx (pharmacy third party administrator)	
Nicole Brown	OptumRx (pharmacy third party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Eric Miller	Segal Consulting (contracted actuarial)	
Quentin Gunn	Segal Consulting (contracted actuarial)	
Zach White	Segal Consulting (contracted actuarial)	
Kautook Vyas	Segal Consulting (contracted actuarial)	
Amy Jiminez	Segal Consulting (contracted actuarial)	
Scott Young	Buck Consulting (contracted actuarial)	
Brian Rankin	Lewis and Ellis (contracted actuarial, Long-Term Care)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	

Sharon Hoffbeck	Retired Public Employees of Alaska (RPEA)
Stephanie Rhoades	Retired Public Employees of Alaska (RPEA)
Wendy Woolf	Retired Public Employees of Alaska (RPEA)
Duncan Fowler	Public member
Delisa Culpepper	Retired Public Employees of Alaska (RPEA)

## Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MA = Medicare Advantage, a type of Medicare plan available in many states
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post-Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits, and the retiree health trust
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment

- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

## Meeting Minutes

### Item 1. Call to Order + Introductory Business

Chair Judy Salo called the meeting to order at 9:00 a.m. A quorum was present.

#### Approval of Meeting Agenda

*Materials: Agenda packet for 8/5/21 RHPAB Meeting*

- **Motion** by Cammy Taylor to approve the agenda as presented. **Second** by Nan Thompson.
  - **Discussion:** None.
  - **Result:** No objection to approval of agenda as presented. Agenda is approved.

#### Approval of Previous Meeting Minutes

Minutes from the May 13, 2021, meeting were not available to members until later in the meeting; the Board postponed action on this item to the September 9, 2021 meeting to allow time for review.

#### Ethics Disclosure

Chair Salo requested that Board members state any ethics disclosures in the meeting and reminded members of the disclosure form available from staff, to keep any necessary disclosures on file.

- No disclosures were stated by members.

### Item 2. Public Comment

Before beginning public comment, the Board established who was present on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that if there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Chair Salo also reminded Board members and members of the public of the following:

- 1) A retiree health benefit member's retirement benefit information is confidential by state law;
- 2) A person's health information is protected by HIPAA;
- 3) Testimony will be posted on the Board's website and will be publicly available, including both written comments and statements made verbally in meetings and recorded in the minutes;
- 4) By giving public testimony on those subjects, the person will be treated as having waived their right to confidentiality regarding the subject of their testimony;
- 5) An individual cannot waive this right on behalf of another individual, including spouse or family member;
- 6) The chair will stop testimony if any individual shares protected health information.

Members of the public who provide comments are also encouraged to submit their comments in writing to the Retiree Health Plan Advisory Board: [rhpab@alaska.gov](mailto:rhpab@alaska.gov).

## Public Comments

- No one in present in the meeting wished to testify during this period.

### **Item 3. Department of Administration + Division of Retirement & Benefits Updates**

Chair Salo asked Emily Ricci to share updates.

#### General Updates

- The Division usually partners with the Pacific Health Coalition to hold health fairs for AlaskaCare members. The Pacific Health Coalition will not be running any health fairs this year, given the concern about risks of COVID-19 at this time.
- Temporary coverage has been extended for flu and pneumonia vaccines for retirees through December 31, 2021. These services are typically offered at health fairs but are still available to retirees at this time. If obtained at a network pharmacy, AlaskaCare will cover 100% of the cost.

#### Regulatory Updates

- The Division is working to update their processes to comply with the No Surprises Act, a federal law passed last year to protect consumers from balance billing in some situations. Balance billing is when a patient billed by a provider for more than their health plan will pay, causing an additional unexpected financial burden. There are also other provisions that most health plans must comply with.  
There is ambiguity as to whether retiree-only plans (like the Defined Benefit plan) are exempted from some of the requirements of the Act. Federal guidance is forthcoming. The Division is tracking this closely, making sure that AlaskaCare complies with the law, and will follow up with more information.
- Kevin Dilg (Department of Law) provided an update on 4 cases of current litigation:
  - Lawsuit regarding the Dental, Vision and Audio (DVA) plan: this case is before the Supreme Court, oral arguments were held April 1, justices are working on a draft decision. A decision is expected at some point in the next year, but timeframe depends on when the justices come to a decision. The main questions in this case are whether the DVA plan is covered under the diminishment clause in the Alaska Constitution and whether the changes made to the DVA plan constitute a diminishment; the Superior Court had previously found the DVA plan is subject to the diminishment clause, and that the changes to the plan were a diminishment.
  - Additionally, another case between RPEA and the State regarding changes made to the medical plan in 2014 is set for trial. RPEA is set to lay out their case on August 30, with additional action the second week of September. There are also a number of pending motions filed.
  - The recently decided Metcalfe v. State case is also relevant: the court decided that former members of PERS, TRS and public employees who have “cashed out” of the plan at a prior point would still be eligible to “buy back in” and re-enter the retirement system. The Supreme Court issued a decision stating that members are eligible, and it has been remanded to the Superior Court to determine more details, such as which members this applies to, and how someone can re-enter the system. The State estimated that approximately 75,000 members are potentially eligible, and this could increase the number of members enrolled in the retiree health plan. He also noted that

this primarily applies to individuals who have been retired for several years, they would need to be reemployed by the State in order to qualify, which may not be feasible or desirable for most people.

- The fourth case, Miller vs. the State of Alaska, addresses how appeals are handled under the Office of Administrative Hearings.

#### DVA Plan Open Enrollment for 2022 Plan Year

Andrea shared an update:

Open enrollment for the DVA plan for retirees will be Wednesday, October 13 through Wednesday, November 24, a 6-week period like previous years. The purpose is for retirees to confirm, update or change their election for choice of dental plan, part of the DVA plan overall.

Information will be mailed to participants in late September, with an overview of benefits, outline of the plan options, and instructions how to make or change elections for the coming plan year.

Emily added that the Division is not anticipating changes to the plans offered, so the process and the plans are consistent with the last three years.

- Judy asked whether members who do not wish to make a change for their plan next year need to take action?
  - Emily confirmed that members who do not want to change their plan election will be automatically enrolled in the same plan for the next year. However, she strongly encouraged all members to review their options and confirm their plan election, even if it is the same plan.
- Judy noted that last year, several members who were previously enrolled in the Legacy plan have elected to the Standard plan? Is this still the trend?
  - Emily confirmed yes, the general trend is that more people are transitioning to the Standard plan from the Legacy plan, and fewer selecting the Legacy plan. This is also true for new retirees, who are tending to choose the Standard. She also noted that the Legacy plan is still the default plan per the court decision in fall 2019, so there is still a higher number of participants in the Legacy plan overall.

#### COVID Update

- Judy noted that meeting participants in Juneau are masked, and Anchorage participants in the room are not. She asked whether state guidelines or mandates have changed?
  - Emily responded no, there is currently no mandate or statewide guideline. It is a choice for employees in the State Office Building, so the team in the room chose to wear masks while in the conference room.

### **Item 4. Modernization Initiatives**

*Materials: Presentation beginning page 16 in 8/5/21 meeting packet*

Judy invited Division staff to present.

#### Specialty Medication Prior Authorization

Emily summarized the process to date: like all proposed changes to the plan, staff have prepared a detailed analysis of the proposed plan changes, including analysis of a variety of impacts. The proposal

(starting on page 16) outlines the proposal to implement a prior authorization process for specialty medications prescribed under the Pharmacy plan. She noted that changes to the plan overall are intended to be cost neutral. For this policy specifically, prior authorization has primarily patient safety and clinical benefits, with potential cost savings as a secondary effect. Betsy will present the proposal.

The Division proposes holding a special meeting in September for the Board to consider taking a position and recommending this change, as well as allowing for a public comment period on this proposed change prior to that meeting. Their outreach plan to members would include letters to members who are currently using one or more specialty medications and would be affected; Town Hall events in fall 2021; communication through RHPAB meetings; and updates on the website.

Emily invited Betsy to present.

Betsy noted that the OptumRx presentations included in the packet (pages 16-43, 44-53) will not be directly addressed today, but were shared at the Modernization Committee meetings and are provided for reference.

Specialty medications are a significant and quickly rising cost in pharmacy plans, particularly retiree plans like AlaskaCare, but this is an overall trend in health plans. Specialty medications are defined slightly differently across plans (such as Medicare versus commercial plans), but are generally designed to treat complex medical conditions, usually chronic in nature. This means patients are often utilizing these drugs for a long period of time as maintenance and ongoing treatment, versus treatment of an acute health issue.

Costs are rising quickly: in 2014, specialty medications were less than 1% of total prescriptions in the retiree plan but 19% of the cost. In 2020, these prescriptions were still less than 1%, but comprised 37% of the cost, a significant increase. Out of over 60,000 plan members who filled one or more prescriptions in 2020, 3.7% of those members (about 2,300) filled almost 11,000 specialty medication prescriptions, out of almost 1.4 million prescriptions in total. This is a relatively small number of members and underscores the significant portion of total cost that this category of drugs represents. Additionally, specialty medications are often utilized for multiple types of conditions, but not necessarily shown to be effective or the best choice for treating that condition; this means there are many “off-label” prescriptions that are intended to treat a patient’s condition, but not all uses of that drug are equally effective according to clinical guidelines.

Betsy noted that this is primarily a process that providers will utilize when writing prescriptions, and most other health plans have equivalent policies for these types of drugs. The intent is not to restrict access to medications, but to ensure that members are being prescribed drugs that are likely to be effective, minimizes any harmful side effects, and has undergone a clinical review.

The primary function of prior authorization is to ensure these prescriptions are following the overall policy of medical necessity already in the plan: the proposed prior authorization process falls under this definition of medical necessity.

- Cammy asked for confirmation the numbered section of the plan booklet for medical necessity.
  - Betsy confirmed that the medical necessity section is 4.5 in the 2021 plan booklet, but 4.6 in the 2020 plan booklet. They are following the 2021 booklet.

Betsy noted that the process is consistent with the prior authorization process in the medical plan, where many procedures and services require a review to ensure they are medically necessary before the



health plan will cover this procedure or service. There is currently not an equivalent policy in the pharmacy plan for specialty medications, which means that prescriptions are not being reviewed before being filled. This means that there is no protection in place for a member who fills a prescription that may not be appropriate for their diagnosis; may have significant side effects or potential harm for them specifically; or have other risks that outweigh the benefits or potential effectiveness of the drug for their individual situation. Prior authorization allows the pharmacy plan to review all of this information and ensure that the benefit outweighs the risk.

Emily noted that the AlaskaCare retiree plan is unusual in not having this type of review; OptumRx shared that their other public sector plans (approximately 61) already have this type of policy. The AlaskaCare employee plan has also had this prior authorization process in place for several years. She reiterated that this is a patient safety provision as well, since it introduced a review prior to the patient going to the point of sale and filling a prescription.

Betsy summarized that this is a common policy in health plans and a key step in protecting patient safety and ensuring plan benefits are utilized effectively. Providers will handle most of the work associated with prior authorization, and any provider who routinely prescribes specialty medications are likely familiar with and required to submit this information for patients covered under other health plans with this requirement. Providers will be required to submit diagnosis and other clinical information about their patient to OptumRx's review team, who will conduct a clinical review of the patient's history, diagnosis, other circumstances, and evidence for utilization of this medication for that diagnosis.

The process is intended to be conducted quickly, with a decision typically within 72 hours (or less, if submitted electronically and integrated with electronic medical record systems). There is also a process for expedited review when needed, with a decision within 24 hours. If a member attempts to fill a prescription subject to prior authorization and this has not been approved, the pharmacist will receive a notice in the system that they cannot fill the prescription until this is complete and can inform the patient they need to follow up with their provider. Members may also call OptumRx to ask whether they need to follow this prior authorization process for their prescription; OptumRx would contact their provider to ensure this follow-up occurs. However, it is standard practice to get prior authorization in other plans, so usually the provider does this without the member needing to take action.

Sara Guidry with OptumRx offered to answer questions and noted that she has prior experience as a specialty pharmacist as well as consulting with patients about specialty medications.

- Nan Thompson asked how the Division or OptumRx will outreach and inform providers about this prior authorization process, to ensure providers are aware of the change and can also let their members know?
  - Betsy confirmed there would be some outreach to providers for this change prior to taking effect in 2022, as well as outreach to members who are currently prescribed one or more of these medications that would be subject to review. Additionally, as ongoing outreach for prior authorizations that need renewal, OptumRx will proactively outreach to providers 30 days in advance to remind them that the prior authorization needs to be renewed for their patient.
  - Sara added that the goal is to engage with providers and members with outreach approximately 60 days in advance (November 1, for a January 1, 2022 start). This will inform providers and members that they will need to complete the prior authorization

process before the policy goes into effect. She added that because providers are accustomed to and expect that they need to complete this process, most of the outreach will need to focus on members to inform them of how this process works and that they need to check in with their provider prior to implementation.

- Cammy asked what the balance between the benefit of this policy versus the additional costs or administrative burden there is on providers. She understands this is a common policy, but how does this impact providers subject to these prior authorizations?
  - Sara responded OptumRx has made process changes over the last several years to make the process easier and quicker for providers. The largest change was shifting from a paper-based system to an electronic system, which is more streamlined and can be completed quickly, but is a change in habit for many providers. Previously, prescriptions were addressed through paper, fax and phone submissions. Additionally, there can be additional time and burden associated with paper-based authorizations, such as a provider not answering one or more questions before the authorization can be complete: it takes longer and more contacts to retroactively ask for missing information, versus the new system that does not allow submitting the authorization paperwork electronically until all the information is completed.
- Cammy asked what the process would be for additional review or a waiver, if a patient's circumstances or condition may not follow general guidelines but may still be appropriate with this case? What options are available to members and providers?
  - Sara shared an example: for Humira, to treat rheumatoid arthritis, the current clinical guidance is that patients should use non-biologic medications first to treat this condition. The standard process under prior authorization would direct patients to try different non-biologic medications. However, there are exceptions: for example, a woman of childbearing age should not use these other types of medications, so an exception or waiver can be granted in that situation, because it is more beneficial to the patient compared with the risks in their specific situation.
- Judy asked what the outreach process would be for members prior to this being put in place?
  - Sara responded members who have been prescribed specialty medications recently (in the last 4 months) would receive a letter 60 days in advance before the policy goes into place. The letter would be targeted to members who are already prescribed one or more specialty medications that would now be subject to the process. The medication(s) would be listed in the letter, to clarify specifically which are subject to this rule.
- Judy asked Division staff what the member outreach and notice process will be, to ensure members are informed about the change?
  - Emily noted this is covered later in the agenda but confirmed that all members will be notified about implementation of this process. She also noted that staff included the OptumRx list of specialty medications, which will be the list utilized in this policy consistent with their other health plans, and includes specific medications listed. Members can review this list at any point to identify whether they have one or more of the prescriptions subject to prior authorization. Staff will also re-review the list of current prescriptions in 2021 to identify who will be impacted:

- Cammy reiterated that much of the outreach will happen in the fall, but she requested that the Division and OptumRx make this list available for members in the online portal earlier than the official notification. Is this list available now?
  - Emily responded the list is not available online for members now, in part because staff are still finalizing the proposal and working through the details during this process. They are not ready for members to access this list, but will work with OptumRx to make this information available and part of the outreach process.

She noted that the last prior authorization process implemented through the EGWP plan was done at least 90 days in advance, but also required significant training and providing information to the customer service center (at Division and OptumRx) so that they were prepared to answer member questions when they began getting contacted. Staff want to ensure they are ready and have the information members need, before proactively sharing this with members and encouraging people to contact with questions.
- Nan pointed out that member outreach and education will be very important, and that members have this information available on the portal as well as other sources. Members will want to know answers to questions such as, “How does this impact me?” and “What do I need to ask my provider?”
  - Emily confirmed they are working to have a robust outreach and set of information for members; it will be a custom request of OptumRx to add this to the member portal as a direct resource for members. They are also ensuring that they are prepared to release the proposal, including the list of medications,
  - Sara noted that there will also be periodic updates to the list, often at 6-month periods (July 1 and January 1); however, there are also changes made as necessary that go into effect immediately. Generally speaking, the list does not change quickly, but the guidelines are specific to each medication and diagnosis
- Nan shared she understood the need to confirm information and that there are timing issues with informing people well in advance, but she strongly encouraged letting members know how they can get information about how this impacts them, such as a phone number to contact OptumRx and ask how the policy will impact them.
  - Sara confirmed they are still working through the process of having access to the clinical guidelines and which team(s) at OptumRx will be available to answer questions. Once they are able to figure out technical capabilities and working through the fact that prior authorization is typically not published for plan members and is considered proprietary information. OptumRx is customizing their portal to make this available to members. The team also needs to determine how to handle changes to the guidelines and ensuring that they have current information as well.
  - Emily clarified there are two questions being asked:
 

First, how can members get information about how the policy will impact them, such as the list of medications and whether their prescriptions are impacted? This is available to members now in the list provided, and OptumRx will be available to provide more information in the near future if this proposal moves forward, prior to taking effect.

Second, how can members specifically review the clinical guidelines for their medication(s) and have access to that information? This is more difficult, and what Division and OptumRx are working through as a custom feature of the plan. They are

not able to have this available in the next few weeks, but plan to have this information in place by November 1 (60 days in advance), if not earlier.

- Cammy asked during this implementation process, after members are notified 60 days in advance, how long before they would expect to have the prior authorization approved?
  - Emily responded the authorization process will typically take the normal time period, within 72 hours after being submitted by the provider for approval. Expedited review is also available if requested or necessary. Typically, if a process takes longer than this time period, it is because there was missing information in the request and the provider was contacted to provide it, which causes delay in the approval process.

*The Board took a 15-minute break at 10:30 a.m., and returned to the meeting at 10:45 a.m.*

### Specialty Medication Prior Authorization, continued

Judy called the meeting back to order.

Betsy continued an overview of the prior authorization process: if there is missing information in the prior authorization request, OptumRx's team will reach out to the provider to get that information as soon as possible. Additionally, if there needs to be additional consultation, the team and the provider can have a peer-to-peer discussion. If the prior authorization is denied, the denial will include specific information and a recommendation for next steps or alternatives for the provider to consider.

- Judy asked the next steps if a prior authorization is denied, who is notified?
  - Betsy responded that the member and provider are immediately notified, so they can respond, provide additional information, or follow up as needed.

Betsy continued: providers will also be directly contacted during the renewal process to remind them to take action for their patient, with no action needed by the member. The provider is prompted to complete that renewal request, it goes through the approval process, and the new authorization takes effect with no interruption in service for the member. The list provided includes the full list of specialty medications meeting that definition, and also indicates which need prior authorization, and for which conditions. Some medications are clearly indicated for some conditions and have few or no serious side effects or complications; these are not necessarily subject to prior authorization. For other medications, such as for certain conditions or where there are elevated risks, prior authorization is needed.

Sara shared information about how OptumRx develops and updates clinical guidelines: the Pharmacy and Therapeutics (P&T) team addresses a variety of needs from new drugs that were FDA approved, to changes to the formulary, to guidelines for prior authorization. This team is responsible for reviewing the most recent information, evidence and guidelines available, and determining how these are integrated into OptumRx's policies. This may include which medications are effective and for which conditions, age range, or other populations; potential downsides or side effects of the medication, or other negative impacts to patients; new indications for specific drugs that are approved for use; and other changes to guidelines. Typically, the guidelines are updated on a rolling 6-month basis (January and July) and can also be updated on an emergent basis if necessary.

Betsy shared that the primary purpose of the review is to ensure patient safety, and that the clinical team does not take cost into account when reviewing, approving or denying a prior authorization request. Cost savings are anticipated to be some degree of financial savings to the plan, but not the purpose of this policy. There are multiple scenarios considered for cost avoidance:

1. If the prior authorization is not approved, and no alternative prescription is pursued. The cost of this prescription was therefore not paid by the plan.
2. If an alternative medication is utilized instead, this could be a cost avoidance—but depends on the relative costs of the original prescription versus the new one. The alternative drug may be cheaper, the same price, or more expensive, but is considered a better choice for clinical reasons. This makes cost avoidance for this situation less clear.
3. If a prescription is abandoned—meaning, a request is made but not completed or followed up—this would also potentially be a cost avoidance, simply because the process was not completed.

Emily added that the preliminary cost savings was estimated to be approximately \$13 million annually, but the team is working closely with OptumRx and actuarial firm Segal to estimate the overall impacts on rebates and subsidies, which are considerable in the retiree pharmacy plan. They are also working with Buck, another actuary who focuses on the pension and retirement plan, to estimate these savings and impacts to the health trust.

- Judy asked whether the September Board meeting has been scheduled?
  - Emily responded this will be addressed later in the meeting.
- Cammy noted that she appreciates the need to ensure members are not prescribed drugs that are not effective or will have harmful effects. However, she would still like to better understand potential cost savings. For example, if most of the cost savings are associated with people being steered toward different medications, this may trigger concerns from members about this being a step therapy policy, which members have not supported. It seems like there is potentially a small number of prescriptions that would be denied, but she is still concerned about this will impact the small number of members who utilize these drugs.
  - Emily appreciated the concerns about step therapy, and interest in understanding cost savings. She noted that step therapy is a cost saving policy and is conducted at the point of sale (pharmacy) and not informed by clinical considerations. Prior authorization is a clinical process and does not consider cost in the decision.
  - Sara added that step therapy is a separate policy and is primarily based on the cost of the medication. She also shared as an example; one drug (Humira) prescribed for one specific condition cost almost \$820,000 for one quarter. The scale and cost of these drugs may be considerable, so even a few avoided prescriptions may represent significant cost savings. However, without having any of the diagnosis or medical history of the patients now, it is difficult to estimate the number of impacted prescriptions.
- Judy noted that the high cost of each individual medication could clearly represent significant savings. Is it possible to provide more detail about the financial impacts, knowing that it's difficult to estimate?
  - Sara noted that it depends on the situation, for example “orphan” drugs for rare conditions often have expedited approval process, but also have complex side effects and are very expensive. Because each individual medication represents a great deal of cost in this specific category of specialty medications, avoided costs can add up quickly even if it is a small number of medications or patients.
  - Emily responded they are working to estimate how impacts rebates and other aspects of the pharmacy plans from a financial perspective. It is possible that they could have increased rebates to the pharmacy plan by having any kind of utilization controls in

place, not just for these specialty medications but generally. Staff were not expecting to see those additional rebates, but are working through this, for EGWP and non-EGWP.

Betsy continued with member impacts: there is a relatively small number of people impacted, but also that this population taking specialty medications could be impacted, and the Division is aware of the concerns this group will have. Outreach will be primarily focused on educating and supporting members who will be impacted, and that their customer service team can answer questions and address concerns. The Division will encourage all members who may be impacted to speak with their provider, with OptumRx, and the Division to understand how they may be impacted and how they can ensure there are little to no impacts on their ability to access medications.

As noted earlier, the change is consistent with the existing Medical Necessity policy, and standard in most other health plans. There will be no change in the number or list of medications covered, and after implementation, there will be relatively small impact on operations of the Division and the third-party administrator (TPA) OptumRx. There will be periodic updates to the guidelines over time which will take some operations time to manage, but this is already in place with the other plans, so there will not be long-term additional burden on staff time to add this to the plan.

Judy invited Board members to share thoughts and comments. She noted that the Board should anticipate a lot of questions and concerns from members, primarily about how this will impact their prescriptions, and Board members should identify what to anticipate and what questions members will want answered. She also noted that it may be perceived as negative, as a change, but also may have positives, since it will mean that people with complex conditions will have additional expertise and review of their case for clinical efficacy and safety. What will members want to know?

Emily reiterated that as shared in prior meetings, specialty medications are a quickly growing share of spending in the pharmacy plan, representing over \$110 million in cost in 2020; without a review process in place, there is no way to fully understand the trends or be able to ensure members are accessing the right medications and avoiding harmful side effects. Putting this review process in place represents a balance among the insurer (the State), the insured (covered lives), and pharmacies. This particular policy is likely to allow for continuing to provide good plan coverage, while achieving potential cost savings.

### Preventive Care Proposal

*Materials: Presentation beginning page 95 in 8/5/21 meeting packet*

Emily shared the summary of the preventive care proposal, which has been discussed in past meetings and has been updated for the Board's review and future vote. Staff are confident that adding these benefits to the plan will have a net benefit: the current plan has limited preventive coverage and expanding this as proposed will bring the retiree health plan in line with other common coverages in similar plans. Members have been frustrated over the years about lack of coverage and have found that Medicare also does not cover all common preventive services. This proposal will help fill in this gap for our members. It has been found that plan beneficiaries will forego preventive care due to this gap in coverage, but then have to deal with downstream health issues that could have been prevented.

Aetna (TPA) has issued clinical policy bulletins showing best practices by for plans and members, and preventive health care coverage options. Aetna recently released such a bulletin; staff reviewed the bulletin to identify the best proposed coverage for the AlaskaCare plan. Members also have access to these bulletins and can review them to compare with the proposed coverage. Staff also stated that

adding these benefits would not create any increase in co-pays or out-of-pocket-costs for in-network preventive services. For those who do not have access to an in-network provider, there would still be a \$150 deductible, which will go toward an out-of-pocket maximum, after which the plan pays the cost as it does today. There is a waiver process through Aetna to allow for an out-of-network provider to be paid at in-network rates; certain conditions need to be met to be eligible for the waiver.

The summary also includes a sample of available services: the list is not exhaustive and is subject to change according to best industry practices by both medical and insurer. We have also looked at the cost impacts to our plan; there is a 0.5% increased impact to actuarial value, which is an addition to the plan benefits, but is estimated to not significantly increase plan costs. There is an estimated \$3.3mil impact in the long term. More details are included in the full proposal summary.

Judy invited questions from the Board:

- Nan asked for clarification about the colonoscopy coverage under this proposal, mostly because there are many different ways to test for this. A provider may conduct or order a test that is not covered under this plan. How will members know what services are covered?
  - Steve Ramos responded that it would depend on the patient's age, since it is not recommended before a certain age range, so coverage for people under 50 would be limited. Preventative screenings, diagnostic tests, and screen are three tiers in the field, and these provide structure to a coverage plan. Most of the preventive benefits for colorectal cancer screenings would be covered for a member starting at 50 years old. He recommended reviewing pages 105-106 in the proposal for more information.
- Nan asked for clarification: are at-home tests covered under the proposal?
  - Blythe Keller responded in-home tests are covered once every 3 years, in addition to a clinical screening by a provider.
  - Emily added that a specialist from Aetna will be available after the lunch break and can answer more detailed questions about what is covered and why. She noted that colorectal screenings in particular are complex, so they are working with Aetna to write very clear guidelines about coverage. Having a screening coded as preventive versus diagnostic is an important distinction.
  - Nan noted she will have additional questions for Aetna this afternoon.
- Nan also asked about wellness visits: she understands that they would not be covered under this proposal, but they are very important in primary care, and recommends they be included. She noted that lung cancer screenings are an example of what should be considered preventive.
  - Emily responded that several years ago, lung cancer tests were not covered as standard preventive care, but this has changed over time; this is also why there needs to be flexibility in what is covered and based on recent information about what's effective.

Emily concluded by reiterating that she has worked on several health plans' preventive care coverage and is excited to see this as an option for retirees. This is necessary for supporting health of the members, and particularly relevant as we see the ongoing impacts of the COVID-19 pandemic and need to reduce and avoid complications due to chronic disease and other conditions that impact health.

Judy thanked the presenters for the information and noted that the group will break for lunch.

*The Board took a break at 11:55, and returned to the meeting at 1:00 p.m.*

Judy welcomed the group back to the meeting.

### **Item 5. Public Comment, Continued**

Chair Salo reiterated the public comment guidelines and invited the public to provide comment.

#### Public Comments

- No one present in the meeting wished to provide comments.

### **Item 6. Modernization Initiatives, continued**

*Materials: Presentation beginning page 63 in 8/5/21 meeting packet*

#### Preventive Care

Emily asked the Aetna team to introduce their staff in the meeting and noted that the preventive care proposal was thoroughly presented at the July 28 Modernization committee meeting, detailed in the document starting on page 96 in the agenda packet. Pages 63-95 are additional information and details. She invited questions and comments from the Board.

- Judy commented that she appreciates the thoroughness and does not anticipate the same level of questions as the prior authorization item, since this has been worked on for several years and members have consistently requested these benefits be added to the plan. She noted that Board members regularly receive comments about preventive benefits, so it is great to be able to share back with members, “We’re working on it, and anticipate this being added soon!”
- Cammy commented that she would like to make clear to members, especially related to the 10 essential health benefits included as requirements of the Affordable Care Act (ACA), that the Alaska retiree plan is exempted from some portions of the ACA, including requirement for preventive care. However, this was generally considered as the “floor” of benefit level for what’s being proposed, with additional benefits included per Aetna’s standard preventive benefits in the health plans they manage.
  - Emily agreed this is accurate and clarified that the retiree plan is only exempt from some of the ACA requirements, preventive care being one of them. Generally speaking, following Aetna’s guidelines will be a higher level of coverage than the ACA requires, especially some specific screenings and who (age range, risk level, etc.) are covered. They have not yet drafted the specific plan language that will be included in the retiree health plan booklet, but the overall policies included are covered in the proposal document and will be drafted soon. She also noted that the “floor” of benefits is not just ACA requirements, but also the guidelines of the US Preventive Services Task Force (USPSTF), the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP), and other relevant guidelines such as for women’s care. All of these are taken into consideration and factored into Aetna’s clinical guidelines, as third-party administrator.
- Cammy suggested that the language should reference not only the benefits covered by the ACA and these other national guidelines, but also reference the TPA guidelines, especially since these are beyond and in several cases more expansive than the national guidelines.
- Judy asked about timing and logistics for the Board’s advisory vote. When will the plan language be available for public comment and review in the plan booklet?



- Emily shared that they anticipate having this drafted in the next 4 to 5 weeks, with a goal of having the plan booklet changes drafted and out for public comment in September. When they implemented EGWP for the pharmacy plan, the Board took an advisory vote in August, and the plan language was available by November. This was a complex implementation, so an earlier timeline for this process is preferred, and their goal is for September. This also requires the Board to make a decision on its recommendation in September, given the implementation required to put this into the plan by January 1, 2022. She also noted that there are many logistical challenges in September, from staff attention to current litigation, to scheduled leave and other requirements. Staff will have limited capacity to hold a RHPAB meeting next month, but it is a necessary step in the process.
- Judy noted that the Board, and members, will want to see plan language drafted during a public comment period. She asked Emily what the preferred process is?
  - Emily responded ideally they would have plan language drafted for review prior to a Board recommendation vote, but the timing of Board meetings and other factors have not made this feasible for some prior advisory votes. She anticipates this will be the case again. Short of having the plan language drafted, what information would the Board want to see in order to make a decision and hold an advisory vote? Additionally, they need to complete a portion of the financial analysis but anticipate having this ready in time for the public comment period. If it is not ready in time for the start of the comment period, they can post it as soon as possible during this period.
- Judy confirmed that the information provided is sufficient in terms of Board members being able to take a vote in a future meeting. She noted that the public comment period will be important.
  - Emily suggested the group take up the discussion about timeline and the public comment process at this time. Her time in September will be extremely limited. The best week is potentially the week of September 6: Monday is Labor Day.
  - The group confirmed that that Thursday, September 9 would be ideal, a short (2-3 hour, morning or afternoon) meeting specific to this item. This meeting will be via WebEx/teleconference.
  - The Modernization committee meeting should happen at least one week prior to the full board meeting. The group considered August 18, 19 or 20, tentatively the afternoon of Thursday, August 19. This meeting will be via WebEx/teleconference.
  - Emily noted that they are proposing that the plan booklet changes public comments, where this proposal will be turned into the actual language to be published, to begin on Wednesday, August 11 and close on Friday, August 27, 2021. Staff can briefly extend this period to accept more comments, such as to Wednesday, September 1, but it takes time to review, redact and organize public comments and share these back with the Board, particularly to avoid sharing or publishing protected health information. She also reiterated that the Division always accepts public comments on proposed changes, or any other aspect of the plan. A person could send comments now, in advance of the release of the draft, or after the official public comments close. However, the deadline indicates the cutoff date for when public comments can feasibly be included in the packet for Board members to review in advance of the meeting.
- Board members confirmed that they are comfortable with the proposed timeline:

- Public comment period as presented (August 11 to 27), and that people can submit comments after that date, they just may not be included in the packet for the September 9 meeting. They will be shared back with the Board when possible.
- Modernization committee meeting will be held the afternoon of Thursday, August 19. By this time, staff anticipate having the financial analysis completed as well. Chair Cammy reiterated that all Board members are welcome to join this committee meeting, even if they are not members of the committee, to learn more.
- Special RHPAB meeting for a scheduled advisory vote on the preventive care proposal on Thursday, September 9 (partial day meeting).
- Judy confirmed that the group has endorsed this schedule and will look for the remaining information (financial and actuarial analysis) from staff later this month. She noted that they are unlikely to receive a great deal of public comment during the August period, given the summer season and that people may be paying less attention to their health plan or official notices. She does anticipate members paying closer attention to this in the fall. While the Board does not currently have enough official information to be able to share a clear update on what the plan will be, there is a great deal of analysis and prior discussions on this proposal available. Where should we direct members to find information before it is officially available?
  - Emily responded the Division uses their website to make all information available to members, and they post all RHPAB materials and other documents there for members to access. They will make this available online, and Board members can direct members to the website to find that information.

Staff will also work to pull out and highlight the specific information about this proposal, so it is not difficult to find in the overall board packets and documents. They will ensure the website is updated and inform Board members where they can direct the public.

The group will continue discussion of this item at the August 19 Modernization committee. The draft plan booklet language will be published on August 11 for public comment.

## Item 7. Dental, Vision and Audio (DVA) Plan & Long-Term Care (LTC) Plan Rates

*Materials: Presentation beginning page 113 in 8/5/21 meeting packet*

### Overview Presentation

Emily shared brief context: the Dental, Vision and Audio plan and Long-Term Care Plans are both AlaskaCare plans, with the State being the plan fiduciary and the third-party administrators managing the plan benefits. She clarified that the Department of Administration Commissioner has authority for setting plan rates, but this is informed by the Division's recommendation and can be informed by a recommendation by this Board. Premiums are set each year in order to balance the estimated total cost of the plan for that year, with an eye toward adjustments year to year to ensure that the rates match the anticipated needs of the plan, meeting obligations in the plan without collecting excess funds.

Richard Ward presented:

The slides beginning on page 113 illustrate how premium rates are developed, the balance of considerations noted above, and how member choice (multiple plans to choose from) is reflected in the differences in rates. Generally, the plan premium rates are determined in order to protect the overall financial health and viability of the plan over the long term. Differences in rates are intended to reflect

the difference in value of each plan (risk, anticipated costs, level of benefits for the member) and can also be adjusted, if one plan choice becomes relatively higher or lower risk.

COVID-19, primarily the early months of the pandemic in March – June 2020, had significant impacts on the utilization and costs associated with the plan, as some coverage was expanded, people delayed or avoided care, and other factors. This has leveled out to some degree and will continue to have impacts over the coming months and years as well. This will impact projections as well and will require ongoing attention and adjustment as conditions change.

Rates are set by reviewing utilization and cost data for prior years, and projecting out for future needs, with timeline for each depending on which plan is being discussed:

1. *Medical and pharmacy plans*: costs are generally stable year to year and projected out to one plan year in advance. Rates are set by looking at anticipated utilization and spend, operational and administrative costs associated with the plan, and these comprise the premiums. For the medical and pharmacy plans, only a small number of retirees pay premiums; much of the projection has to do more with the performance of the OPEB and health trusts to determined estimated State contributions for this plan. Rates for this plan only impact some members.

Given the recent trend of lower costs in this plan, for the last several years, the plan's premiums are more than sufficient to reduce rates for this plan. The biggest reason for this shift is the relative larger number of Medicare eligible retirees, whose health care costs are more fully covered by Medicare.

- Nan asked about the impact of the delay in receipt of rebates from the federal government, which was reported on yesterday in the vendor meeting. Does this negatively impact the plan's rate setting, is that reflected in the financial information?
  - Richard responded the plan has several billion in assets, and so a delay in payment for subsidies would not impact the plan's ability to pay claims. It is a consideration and not ideal if paid later, but there is certainty that it will be paid, so it is not a problem for rate-setting at this point.
  - Emily noted that there are two significant lines reducing the State's liability in the plan: the pharmacy prescription rebates, as well as subsidies (primarily EGWP). Together these are approximately \$123 million in offsets to the plan liability, which is significant. This is why tracking impacts on rebates and subsidies is very important and could have a major impact on the plan.
  - Richard noted this is a common concern for other health plans as well.

Richard continued: the table on page 118 illustrates proposed rates for retiree premium rates for 2022, which is no change from 2021. The table on page 119 illustrates the per member per month costs, including Medicare and non-Medicare members. A Medicare member has approximately half the month cost on average compared with a non-Medicare member. He also noted that the impacts in 2020 (fewer claims, lower spending) impacted the costs of Period 2. Comparing the vendors' performance in their timeframes, versus the state fiscal year, the timeframe with the biggest drop in costs (spring 2020) are included in different periods. While spending was lower in 2020, it is unclear how much this trend will continue: this is why Segal recommends a flat rate (no change) and monitoring how this changes in the future. This will minimize potential risk of underfunding, provides more stability for members by minimizing

changes year to year, and allows for an additional study period and revisiting this question next year, for a possible rate change.

2. *Dental, vision and audio (DVA) plan*: This plan is also projected out over 1 future year for rate changes. Prior to the introduction of the Legacy plan and options for members, there were few changes in recent years to the dental plan, so rates were stable for multiple years. During that year, the assumptions setting the plan rates and their approval in September were finalized prior to the court decision to require the Legacy plan to be the default enrollment for retirees. This introduced unknown risk to the plan, and more so than the medical plan because premiums comprise the entire funding for this plan (members, not the health trust, pays the cost of this plan). It is important for this plan, fully funded by member premiums, to stabilize rates: the goal is to avoid spending down the plan reserves too quickly and having to make a sharp increase in rates in a future year if reserves are drawn down. Instead, it's best to "smooth the curve" of rate increases and decreases, with a goal of flat rates as much as possible, to avoid bigger corrections that impact members more year to year.

Currently, the DVA plan is estimated to have approximately \$50.7 million in estimated costs for 2022, compared with about \$48.5 million in revenues. There is currently a shortage or gap between revenue and estimated spending, approximately \$2.2 million or 4.3% of total. While there is gap in when services are performed and when a claim is paid out of the plan trust. The actual estimated liability as of December 31, 2022, is slightly less, \$3.8 million, because some claims for services at the end of the year will not be billed to the plan until early in 2023.

While this overage in potential claims is concerning and needs to be monitored, Segal is not recommending rates to be increased for the coming year, for either the Standard or Legacy plan, and instead matching 2021 levels. There are sufficient projected assets to cover these costs; reviewing the performance of the plan in the next few months will also be a good indicator for the coming year. However, Segal also recommends contemplating a rate increase in 2023, depending on how this plan continues to perform, as well as looking more closely at the rate difference between the Standard and Legacy plans. The chart on page 123 shows a trajectory for future rate increases, based on this current trend, and how to manage the need for future increases and avoid a sharp one-year change. As an example, Segal may recommend an approximate 5% increase year over year in the next few years, or 4.5% increase beginning in plan year 2026. However, this all depends on the ongoing trend and spend-down of the plan's assets as claims are made, so this could change in the future.

- Judy commented that it seems beneficial to keep rate changes to a minimum, for continuity, but also noted that many members may not notice a slight increase or decrease year to year, depending on their financial situations.
  - Richard responded the group discussed a very modest decrease but determined that it would be more prudent to keep rate flats.
- Judy noted that Lorne Bretz is on RHPAB as well as the Alaska Retirement Management Plan (ARMB), so he has the perspective of both the financial management and plan management.

Emily shared that because there was little prior information in 2019 to establish differences between the Standard and Legacy plans, so they had to use proxy information. 2020 was also not useful experience for setting rates, given how different that year was. However, staff will be looking

closely at that prior performance when looking at the rates, and the differences between the Standard and Legacy plans based on actual performance. There may be adjustments between the differential between rates in a future year, if the data suggests this is beneficial.

She also noted that staff will be seeking discussion and recommendations from the Board about setting objectives for asset levels in the DVA and LTC plans, which are both funded by member premiums. They will bring more information at a later time, asking for guidance from the Board.

3. *Long term care (LTC) plan*: Unlike the other plans presented above, the long-term care plan is utilized over a much longer time period: premiums are paid in often years before a member utilizes those benefits. The LTC plan therefore does need rates reviewed regularly, but the actuarial valuation is conducted every two years, and over a longer time period. This also includes long-term considerations such as mortality rates for members and the number of people who are likely to utilize significant benefits under this plan.

The table on page 125 illustrates net present value for the plan's benefits, expenses and premiums collected over time. The investment gains have been larger than expected, meaning that there are more assets, and the plan is more funded than it was a year ago (121% of liabilities last year, versus 154% this year). However, the investment returns can change significantly year to year (the table on page 126 shows how the large gain this past year is unusual). Additionally, because of the uncertainty in how many people will use these benefits over a long period of time, a short-term gain should not necessarily trigger a rate decrease, because it can change over time and the general trend of an aging population with complex medical needs. Therefore, Segal recommends keeping rates flat for 2022 as well, and not assuming that this short-term trend will hold long term. The LTC plan for AlaskaCare is self-insured by premiums, but it can be very difficult to find commercial plans that are adequately funded, as several insurers have over-subscribed their plans or not collected enough premiums and ended up with major liabilities they could not adequately cover.

- Judy asked for clarification: premiums are paid by members at the point of enrollment, usually at retirement, until they pass away, is that accurate? How is life expectancy used in projections?
  - Richard responded yes, this is similar to a pension plan, which uses mortality assumptions based on life expectancy (not just morbidity assumptions, which are based on estimated disease rates and other medical needs in a year). He noted that the long-term care needs are projected over several years and included as net present value to show the present value of the plan.
  - Brian noted that there are multiple plans offered, with different levels of coverage, so this is also factored into the projections for the plan and how many members are covered at what benefit level.
- Judy noted that overall life expectancy in the U.S. is expected to decrease slightly as a result of the impacts of COVID-19. How will this impact the plan projections, and whether it is adequately funded? Is the investment performance the biggest impact on the plan?
  - Richard commented that projected life expectancy does have an impact, but he also noted that the plan is well funded (over \$700 million in assets), and this closely matches projected expenditures now. Short-term fluctuations in the investment value and/or changes to life expectancy like those related to COVID-19 are relevant, but not necessarily large impacts to the plan long term.

- Cammy asked who manages the investments?
  - Emily confirmed that the Department of Revenue, Division of Treasury manages this plan fund. Staff met with the state’s Chief Financial Officer recently to discuss this plan and ensure that their investments (employee health plan fund, DVA plan and LTC plan) are managed according to the differences and considerations for each plan. She requested that Revenue staff present at a future Board meeting for information.
- Lorne asked if enrollment for the LTC plan has increased or decreased, what is the trend? He noted the DVA plan has seen a slight decrease in enrollment, is this happening in the LTC plan?
  - Brian noted that there is a net increase in the number of premiums collected, so there are slightly more people entering the plan than are exiting the plan (deceased or disenrollment).
- Lorne noted he is curious in whether retirees are still enrolling in these plans, or if retirees are less interested in this plan.
  - Emily commented that she does not have specific numbers on the trend but noted that the premiums in this plan and availability of the plan is relatively attractive, since they are harder to find in the private sector. It is hard to find a LTC plan
  - Brian added that a significant increase in overall premiums indicates probably that more members are signing up; some people may have also switched to higher-value plans, but there are a larger number of people

Emily summarized the recommendations: Segal has recommended to the Division that premium rates would stay flat for 2022 across all plans.

Board Recommendation and Vote

- **Motion** by Nan Thompson to adopt the presented recommendations (no rate changes) for 2022 for the Medical, Pharmacy, DVA and LTC plans. **Second** by Lorne Bretz.

**Result:** The board voted on Resolution 2018-01 as amended.

Bretz	Hall	Hargrave	Harrison	Salo	Taylor	Thompson
Yes	[Absent]	[Absent]	Yes	Yes	Yes	Yes

**Item 7. Closing Thoughts + Meeting Adjournment**

Closing Thoughts

The group proposed review and approval of the May 13 minutes at the September 9 meeting, to give Board members additional time to review. This will be included on that agenda.

2021 Board Meetings

The board’s meetings are scheduled as follows for the remainder of 2021. For regular meetings, quarterly vendor meetings will be held the day before (Wednesday).

- Thursday, September 9, 2021, 9 a.m.-noon (special meeting: vote on Preventive Care)
- Thursday, November 4, 2021 (regular quarterly meeting)
- Additionally, there will be a Modernization committee meeting on Thursday, August 19, 1-4 p.m.

**Motion** by Cammy Taylor to adjourn the meeting. **Second** by Nan Thompson.

**Result:** No objection to adjournment. The meeting was adjourned at 2:56 p.m.

---

The next Retiree Health Plan Advisory Board meeting will be Thursday, November 4, 2021.

DRAFT

## Retiree Health Plan Advisory Board

### Modernization Committee Meeting Minutes

Date: Thursday, August 19, 2021, 1:00 to 4:00 p.m.

Location: Virtual meeting via teleconference and WebEx only

#### Meeting Attendance

Name of Attendee	Title of Attendee	
<i>Retiree Health Plan Advisory Board (RHPAB), Modernization Committee Members</i>		
Cammy Taylor	Committee Chair	Present
Joelle Hall	Committee Member	Absent
Nanette (Nan) Thompson	Committee Member	Present
Judy Salo	Board Chair	Present
Dallas Hargrave	Board Member	Present
<i>State of Alaska, Department of Administration Staff</i>		
Emily Ricci	Chief Health Policy Administrator, Retirement + Benefits	
Betsy Wood	Deputy Health Official, Retirement + Benefits	
Teri Rasmussen	Program Coordinator, Retirement + Benefits	
Andrea Mueca	Health Operations Manager, Retirement + Benefits	
Steve Ramos	Vendor Manager, Retirement + Benefits	
Elizabeth Hawkins	Appeals Specialist, Retirement + Benefits	
Christina Vasquez	Appeals Specialist, Retirement + Benefits	
Mike Gamble	Health Care Economist, Retirement + Benefits	
Chris Murray	Member Liaison, Retirement + Benefits	
<i>Others Present + Members of the Public</i>		
Nicole Brown	OptumRx (pharmacy third party administrator)	
Lauren Carney	OptumRx (pharmacy third party administrator)	
Sara Guidry	OptumRx (pharmacy third party administrator)	
Carrie Sather	OptumRx (pharmacy third party administrator)	
Richard Ward	Segal Consulting (contracted actuarial)	
Noel Cruse	Segal Consulting (contracted actuarial)	
Scott Young	Buck Consulting (contracted actuarial)	
Anna Brawley	Agnew::Beck Consulting (contracted support)	
Patricia Nault	Public member	
Jeanne Miller	Public member	
Sue Nielsen	Public member	



## Common Acronyms

The following acronyms are commonly used during board meetings and when discussing the retiree health plan generally:

- ACA = Affordable Care Act (formal name: Patient Protection and Affordable Care Act)
- ARMB = Alaska Retirement Management Board
- CMO = Chief Medical Officer
- CMS = Center for Medicare and Medicaid Services
- COB = Coordination of Benefits
- COVID-19 = Novel Coronavirus Disease (identified 2019), also known as SARS-CoV-2
- DB = Defined Benefit plan (for Tier 1, 2, 3 PERS employees and Tier 1, 2 TRS employees)
- DCR = Defined Contribution Retirement plan (Tier 4 PERS employees, Tier 3 TRS employees)
- DOA = State of Alaska Department of Administration
- DRB = Division of Retirement and Benefits, within State of Alaska Department of Administration
- DVA = Dental, Vision, Audio plan available to retirees
- EGWP = Employer Group Waiver Program, a federal program through Medicare Part D that provides reimbursement for retiree pharmacy benefits
- EOB = Explanation of Benefits, provided by the plan administrator detailing claims coverage
- HIPAA = Health Insurance Portability and Accountability Act (1996)
- HRA = Health Reimbursement Arrangement account, a mechanism for the employer to reimburse high-income Medicare enrollees for any premium charge for their plan (IRMAA)
- IRMAA = Income Related Monthly Adjustment Amount, a surcharge from CMS for a Medicare plan for individuals or households earning above certain thresholds
- MA = Medicare Advantage, a type of Medicare plan available in many states
- MAGI = Modified Adjusted Gross Income, based on an individual or household's tax returns and used by CMS to determine what if any premium must be paid for a Medicare plan.
- OPEB = Other Post-Employment Benefits; an accounting term used to describe retirement benefits other than pension benefits
- OTC = Over the counter medication, does not require a prescription to purchase
- PBM = Pharmacy Benefit Manager, a third-party vendor that performs claims adjudication and network management services
- PEC = proposal evaluation committee (part of the procurement process to review vendors' bids)
- PHI = protected health information, a term in HIPAA for any identifying health or personal information that would result in disclosure of an individual's medical situation.
- PMPM = Per member per month, a feature of capitated or managed-care plans
- PPO = Preferred Provider Organization, a type of provider network
- RDS = Retiree Drug Subsidy program (a federal pharmacy subsidy program)
- ROI = Return on Investment
- RFP = Request for Proposals (a term for a procurement solicitation)
- RHPAB = Retiree Health Plan Advisory Board
- TPA = Third Party Administrator
- USPSTF: U.S. Preventive Services Task Force

## Item 1. Call to Order + Introductory Business

Chair Cammy Taylor called the committee meeting to order at 1:05 p.m.

### Approval of Meeting Agenda

*Materials: Agenda packet for 8/19/21 RHPAB Modernization Committee Meeting*

1. **Motion** by Judy Salo to approve the agenda as presented. **Second** by Nan Thompson.
  - o **Result:** No objection to approval of agenda as presented. Agenda is approved.

### Ethics Disclosure

Cammy Taylor requested that committee members state any ethics disclosures in the meeting. No members made ethics disclosures.

## Item 2. Public Comment Period + Communications Updates

*Materials: Documents beginning on page 2 of the 8/19/21 agenda packet*

Emily Ricci provided an overview:

Staff have launched the public comment period as planned, intended to run from Wednesday, August 11 through Friday, August 27. She also noted that the Division is working toward the Board's advisory vote on these proposals at the upcoming September 9 special meeting. She emphasized the importance of good communications and member outreach, along with other planning for implementing the changes, and noted that lessons learned during the 2014 retiree plan changes were followed up for the 2019 plan changes, with better results for members and the Division. The timeline is tight, especially given the time needed prior to implementation of these policies in January, but they have received several requests to extend public comments. The Division has extended the public comment period to Friday, September 3. She noted that this is a tight timeline for turnaround and inclusion in the Board's packet for September 9, but also that the Division always accepts public comments, regardless of the timeline, and encouraged members to do so, either now or later in the fall, and that the Division always reviews comments and shares them with the Board.

She also shared the plan for outreach to members:

1. Members are being mailed a postcard (the postcard is being processed as of this meeting date) and will be reaching members in the next several days, within Alaska and in other locations.
2. Staff have scheduled an additional Tele Town Hall on Wednesday, September 1, to inform members about these proposals, answer questions, and encourage members to give feedback. They are also anticipating scheduling one or more Town Halls in the fall as implementation moves forward, to continue educating members and answering questions.
3. Staff have also prepared summary materials about the proposals (page 4 of agenda packet) including overviews of the preventive care benefits and specialty pharmacy prior authorization proposals. The flyers also answer frequently asked questions (FAQs), including summarizing questions asked to date, and let members know how to find more information and stay informed.

- Nan Thompson appreciated the contents of the flyer and focus on FAQs. She recommended better defining “third party administrator” and referencing Aetna specifically, as well as briefly explaining or letting members know what this means. This term may be confusing.
  - This is helpful feedback; staff will make this change.
- Judy asked where these materials can be found online?
  - Emily confirmed the materials shared in the packet are online at: <http://www.alaskacare.gov/retireeupdate>  
This page can also be found as a link on the Division’s website as part of the Retiree Health Plan Advisory Board page, as well as being highlighted as one of the news headers on the main AlaskaCare page. All navigate to the same page.  
The page includes detailed information about the proposals, FAQs, and how to contact the Division or provide comments.
- Judy asked for clarification on key dates.
  - Wednesday, September 1 is the Tele Town Hall focusing on these proposals.
  - Friday, September 3, is the revised comment deadline (originally August 27).
  - Thursday, September 9 is the RHPAB special meeting to consider an advisory vote.

#### **Item 4. Working Session: Pharmacy Prior Authorizations**

*Materials: Presentation beginning on page 7 of the 8/19/21 agenda packet*

Emily Ricci shared an update on the financial analysis of this proposal: Segal Consulting has been working to estimate financial and actuarial impacts, including potential plan savings. The original estimated savings was approximately \$13 million, but they anticipate revising this downward slightly, and the numbers presented today will likely be revised further down.

Emily invited Richard Ward to speak to the analysis:

Richard shared that they do not anticipate the actuarial value of the proposal will change, because it is not changing the key cost sharing provisions of the plan, and instead is a process change for review and authorization for certain medications.

To estimate the financial impacts of the plan change, which is not limited to actuarial value, Segal and staff are still sorting this out. While the actual costs in terms of claims need to be estimated, in addition these changes will impact the rebates and EGWP subsidies that need to be accounted for. Implementing utilization policies (like prior authorization) has a favorable impact on the level of rebates the State can access for the retiree plan. These changes would also negatively impact some EGWP subsidies because they may represent less utilization of certain medications, but the reduction in those subsidies will be more than offset by the net positive to other rebates. The table on page 22 illustrates the current estimated net savings, including where subsidies and rebates will increase or decrease. Segal is updating its estimates, but still anticipates a net positive in savings to the plan.

- Emily asked Richard to comment on which categories of estimated savings may change most?
  - Richard commented he anticipates the first and third (claims savings and EGWP subsidies) to be the primary changes. The primary positive savings are related to the fact that having utilization review policies, like proposed, in the plan allows the State to access a higher level of rebate, and not changes to individual rebates for prescriptions, if

there is not a significant change in utilization, they assume that a large majority of retirees will still be using the same medications as they do today. Richard also summarized the savings (about \$7-8 million) to be just over 1% in actual savings, which is consistent with the experience of other plans.

- Emily added that the complexity of the modeling has made assumptions about cost savings difficult, and that this policy will be added to the plan, versus having been in place for several years, so it is difficult to compare with other plans.
- Cammy asked how claims savings are calculated?
  - Richard Ward shared that Segal only provides estimates, but they use the experience in other retiree plans, including approval rate of prior authorizations for these medications, the baseline utilization in the current plan, and utilization in the employee plan to understand and estimate potential changes.
- Cammy asked whether and how they also use individual categories of drugs, given that these prior authorizations have varying approval rates by drug category, is this factored in?
  - Richard confirmed that they do look at the approval rate of prior authorization, and that they adjusted this number to assume most prior authorizations will be accepted, especially given that many retirees are already using medications successfully when this is implemented. He noted that it does differ, but they are simply producing estimates.
- Cammy asked if Segal is using detailed data by drug category, for example is it common now to see 90% approval rate in some categories?
  - Richard responded they worked with OptumRx's detailed analysis of these drugs by category, and that their estimates are still relatively general and difficult to describe in much detail. He encouraged OptumRx to speak to specifics on drug categories.
  - Emily added that part of the difficulty in estimating approval rates is because individual drugs may have multiple indications, where it is clearly indicated for one condition (and therefore will likely always be approved) but may have more limited or mixed results for other conditions. So, the approval rate is not only related to the drug category, but the specific drugs and conditions they are approved for. Oncology drugs is an example.
  - Sara Guidry shared that for oncology, for example in the employee plan, most of the medications listed are not necessarily subject to prior authorization. There were approximately 20 rejected claims in a one-year time period; most are generally covered. Most claims for these types of medications are typically approved. However, there are also other factors: perhaps the patient needs to undergo a different treatment, or another procedure, before using this medication, or may decide on different treatment.
- Cammy asked, given that the intent of this policy is to ensure patients are accessing specialty medications safely and with minimal risk of side effects or complications, are there specific types of drugs where this policy is the most relevant?
  - Sara responded there are pediatric growth treatments, which may be accessed in other situations, but which would be less likely to be approved for older adults. Another example is pediatric asthma medications, which generally recommend drugs administered orally or as a spray, versus ones that are injected. Generally, the clinical guidance is to try the sprays first before injection, but also depends on circumstances.
- Cammy asked about the anti-hypo lipidemic category, as an example: one of the drugs has a prior authorization required, while the other does not. She also noted that the latter drug, not

requiring authorization, is more expensive. She asked more generally, what are the reasons for why some require approval and others don't?

- Sara will research this specific drug and report back to the Board. She noted that generally, it depends on the strength of the clinical evidence for each medication and indication. This does not have to do with cost, but whether it is known to be effective, or if there are other factors such as side effects or complications.
- Emily added that this is a good example of where the more costly medication is not subject to review, because there is already strong evidence that it is effective and does not need additional review. This policy is generally focused on patient safety, not cost.
- Nan asked how often EGWP rebates and other subsidies change?
  - Richard shared that this occurs at the federal level (CMS), since it is a Medicare Part D program, and they are reviewed annually (but do not necessarily change year to year). He gave a general overview of trends in rebates and subsidies: some are larger than others, and they do not change regularly. There has been a reduction in the base EGWP subsidy, but it is offset by increased subsidies in catastrophic reinsurance and especially rebates for medications. AlaskaCare receives about \$60 million per year in total subsidies.
  - Emily added that subsidies and rebates are tracked monthly, and quarterly updates are provided to the Board; they do a final calculation of total annual subsidies.

Emily invited Scott Young with Buck Consulting to provide an overview of estimated impact to the total plan liability as a result of these changes:

Scott shared their actuarial analysis is focused on the impacts to the Health Trust, including required contributions to the plan by all entities (including the State and other jurisdictions, for each retiree group) and the impact to the unfunded liability, or what is required to cover all estimated health care costs long term. He noted that their calculations are in net present value, or the total estimated value of the plan over time, adjusted to one dollar amount. This proposal is estimated to represent savings to the plan overall (approximately \$172.2 million in total); the plan is overfunded currently, so there is no actual change to the required contribution—but this estimate is provided as well, what the reduction in required contribution would be if it was necessary to contribute. This is estimated to have a positive overall impact on the long-term health of the plan.

- Judy asked for clarification: the Health Trust is overfunded, but the Pension Trust is still underfunded? Can the savings from this impact the pension side?
  - Scott clarified no; statute specifies that the resources from one plan cannot be transferred to the other. This will positively impact the Health Trust but will not have an impact on the fact that the pension is underfunded.

Cammy invited general questions from Board members.

- Cammy asked, given that the proposal is to follow the TPA (OptumRx's) clinical guidelines, are there national standards in addition to FDA and other guidelines?
  - Sara responded yes, there is not one single guideline, but there are national standards and sources. Each individual guideline has references that indicate the source(s) of the guidance would be similar.

- Cammy asked whether OptumRx ever differs from these guidelines?
  - Sara responded generally their review committee closely follows available national guidelines. Where they may differ, they may for example determine that adding a specific age range (which is in the national guideline) is not necessary, so they have a broader coverage policy than simply following the guideline.
  - Emily added that generally, the Division always weighs what they should prepare or manage in-house, and what should or would be best contracted out. She noted that it is not feasible for the Division to prepare clinical guidelines, with that level of expertise and effort needed to develop them, and it would not be feasible for other departments to provide this either. OptumRx hires staff and has processes to develop these guidelines, and also partners with other entities to develop some guidelines they do not have capacity to do. The complexity and number of guidelines make it most feasible to pay for another organization's expertise and management, and for the Division to focus on coverage policies for members and for managing the administrator contracts. She noted "Why doesn't the Division do this themselves?" is a common question. She also noted that there are differences among PBMs, including these kinds of guidelines.
  - Sara added that creating and updating guidelines is a complex job, which OptumRx utilizes a lot of staff expertise to create.
- Cammy asked for clarification about step therapy: she shared that many retirees are worried about having to follow a step therapy policy and did not support Aetna's policy to require this. Step therapy is a policy that requires using a generic or other lower-cost medication before a patient can access or be approved to utilize a brand name or other drug they would prefer. She asked, for example: this policy is put into place, and as a result, very few denials occur, and most authorizations are approved. This would not result in the projected cost savings, since most or all medications were approved. It would suggest that the medical necessity guidelines are working as intended, since claims were consistently satisfying medical necessity, but (hypothetical) no cost savings. Will there be any pressure to produce further cost savings as a result, if this policy does not achieve that result?
  - Sara responded there is no mechanism to pursue additional savings through this policy, and it would not change the outcome of the claims being paid. This is not a cost saving measure, even if it has additional cost avoidance as a result and would not alter OptumRx's payment of claims.
- Cammy commented on the analysis identifying Low Member Impacts: she understands that this proposal will only impact people who utilize specialty medications that will be subject to this prior authorization process, a relatively small number of people in terms of the overall population covered by the plan. However, she noted that the Board is very interested in impacts to individual members, and in this situation often includes people with complex or chronic conditions, including terminal or life-threatening conditions, and that accessing benefits is extremely critical to their quality of life. Even if the number of people impacted is small, the scale of impact on these members could be very big.
  - Emily agreed, and affirmed the Division is also considering and prioritizing how policies can significantly impact members. Staff will revise the document to reflect impacts more accurately: that most members will unlikely access these benefits year to year, but the (relatively) few who do have a significant stake in this policy working. The process is not

expected to significantly impact their ability to access medications, since it is a standard practice in many other plans, and providers are familiar with how to work with plans to get authorization on behalf of their patients. But, during the transition period for existing medications, and in situations where a prescription is not authorized, there could be impacts in terms of time and administrative burden to resolve the issue. In any case, the provider is expected to handle most if not all of the authorization process.

*The Board took a 15-minute break at 2:30 p.m., and returned to the meeting at 2:45 p.m.*

#### **Item 4. Public Comment**

Before beginning public comment, the committee established who was present on the phone or online, and who intended to provide public comments. Individuals were asked to state their full name for the record, and that if there are several people wishing to provide comment, comments will be limited to 3 minutes per person, at the discretion of the chair. Chair Cammy Taylor also reminded Board members and members of the public of the following:

- 1) A retiree health benefit member's retirement benefit information is confidential by state law;
- 2) A person's health information is protected by HIPAA;
- 3) Testimony will be posted on the Board's website and will be publicly available, including both written comments and statements made verbally in meetings and recorded in the minutes;
- 4) By giving public testimony on those subjects, the person will be treated as having waived their right to confidentiality regarding the subject of their testimony;
- 5) An individual cannot waive this right on behalf of another individual, including spouse or family member;
- 6) The chair will stop testimony if any individual shares protected health information.

Members of the public who provide comments are also encouraged to submit comments in writing to the Retiree Health Plan Advisory Board: [rhpub@alaska.gov](mailto:rhpub@alaska.gov). Comments are sent to all Board members.

No one present wished to provide public comment at this time; one public member commented later.

#### **Item 5. Additional Questions + Discussion**

##### **Board Comments**

Cammy invited any additional questions or comments from Board members.

- Judy Salo commented prior authorization for these medications seems to be mostly for members with complex chronic conditions and would therefore be taking them for years or permanently. What is the typical prior authorization length, and what are examples of short prior authorizations?
  - Sara shared typically authorizations for medications treating chronic conditions are good for one year, particularly if the member has already been using this drug and is responding well or not having negative side effects. In other cases, particularly for treatments for more acute conditions, the authorization may be shorter, but it depends on the clinical guidelines for that medication and condition.  
For example, typically treatments for Hepatitis C can have varying length; the

recommended treatment regimen depends on the patient's condition and other factors. Authorization in this case may be shorter term, specific to the regimen of treatment that the person receives and other factors, based on current guidelines.

Oncology treatment is another example, as it is for a specified period of time; there may be multiple options available, but it will depend on what's ideally recommended for the

- Judy commented for people with deteriorating conditions, it could be burdensome on the patient to seek reauthorization. She hopes that the provider or healthcare advocate would take the lead on seeking reauthorization, and not burdening the patient further.
  - Sara responded this is certainly a valid concern. The prior authorization process is commonplace, particularly for specialty providers prescribing these medications, and the general expectation is that the provider manages this and proactively takes action on behalf of the patient. Additionally, she noted that while use of a specific specialty pharmacy isn't required in this plan, usually members access these medications through a specialty entity and not a retail pharmacy, so they are also well versed in using this process. This is another place to proactively notify and is often part of the service a specialty pharmacy provides. OptumRx also reaches out to providers for any authorizations expiring soon, proactively reminding them to complete the process.
- Judy asked whether OptumRx currently has any information about specialty pharmacy claims, whether the prescribers are making appropriate decisions based on clinical guidelines, and what negative impacts might be happening now for members if they are not being prescribed the best choice for their condition?
  - Sara responded OptumRx does not have that information now, they only receive claims to be paid and do not have access to the diagnosis or other clinical information that led to that decision. She noted generally authorizations for first-time medications, or within the first few months of a treatment, are shorter because there is a process of checking in with a patient's specialty provider to ensure they are responding well to that treatment or medication. This should not interrupt the patient's ability to access their medication, it simply means that the provider would be in more frequent communication with OptumRx (via re-authorizations), but it is part of the care process.

## Public Comments

- Pat Knowles, a public member, asked a question: given the difficulty accessing specialty care in Alaska, will this negatively impact members who live in Alaska, such as requiring them to travel to Anchorage or another community to see a provider, before prior authorization would be approved? She also commented that she has been familiar with retiree plan changes over a period of time and found that there is always a lot of confusion and frustration from members about change. She appreciated the attention to keeping members informed and stated this should be a priority.
- Cammy asked how other logistical or individual patient circumstances might be factored in: if a person lives in a rural area, and has limited access to a specialty provider, pharmacy, or other services like having routine blood tests, would this be factored into a decision for a patient's prior authorization? If there are two alternatives for medication, one of which is less costly but requires more regular checks like a blood test, but which would place more burden on the member in order to follow the required usage?



- Sara responded step therapy is a policy requiring use of a standard, “first line” medication and does not allow a person to utilize some medications without having tried the standard treatment first. In the prior authorization process, in contrast, the guidelines may generally recommend not approval, but also include specific contraindications, situations where the drug would still be approved, and/or individual exceptions granted depending on circumstances.
- Emily added, responding to the concerns about accessing specialty providers: in recent years the growth of telemedicine, particularly for specialty consults, has greatly increased access for Alaska members, primarily providers in state, but increasingly out of state as well as policies change to allow this coverage. This will also significantly help members access specialty care, for example if they have a routine follow-up confirming that the medication is still working for them.
- Pat asked for clarification: how telemedicine is covered in the retiree plan? She understood many of those coverage changes to be related to COVID-19 only, and are not continuing?
  - Emily shared telemedicine benefits were expanded in part to respond to the COVID-19 pandemic, but this has been a general trend as well in expanding access to care. She clarified that coverage of telemedicine benefits have been expanded (similar to changes made in Medicare and commercial insurance plans) and will continue, but the Division is discontinuing specific offering of Teladoc, a service that provides some telemedicine services. The Division offered this to retirees, but have seen very low utilization, declining in recent months, and therefore the cost for having a subscription and coverage for members exceeded the potential savings it was expected to bring to the plan, by allowing members to access care without having to travel or schedule an in-person visit in all circumstances. So Teladoc will no longer be covered, but generally the expanded telemedicine benefit will be.

#### Item 5. Closing Thoughts + Meeting Adjournment

The Retiree Health Plan Advisory Board will hold a special meeting on Thursday, September 9, 2021, to consider the preventive care benefits and specialty pharmacy prior authorization.

4. **Motion** by Nan Thompson adjourn the meeting. **Second** by Judy Salo.
  - **Result:** No objection to adjournment. The meeting was adjourned at 3:40 p.m.

Executive Summary	<b>Expanded Preventive Coverage (R007)</b>	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 <sup>st</sup> , 2022	
Reviewed By	Retiree Health Plan Advisory Board	
Review Date	September 9, 2021	

**1) Background**

The AlaskaCare Defined Benefit Retiree Health Plan (Plan) provides benefits necessary for the diagnosis and treatment of an injury or disease, but outside of a few specific services (mammograms, Prostate-Specific Antigen testing, and Pap smears), the Plan does not provide coverage for preventive care. The Plan is exempt from federal requirements mandating coverage for most preventive services.

Most active employee plans include coverage for preventive services, as does Medicare (which becomes primary for members at age 65). When retirees and their dependents enter the Plan, they are often surprised and frustrated by the absence of coverage for most preventive services. The lack of Plan coverage for most preventive benefits may result in members without other coverage foregoing recommended age-specific vaccinations, screenings, and other preventive services.

**2) Objectives**

- a) Support members in maintaining their health.
- b) Promote high-value care.
- c) Increase accessibility to patient care for non-emergency health episodes.

**3) Summary of Proposed Change**

The Division of Retirement and Benefits proposes adding the full suite of evidence-based preventive services in alignment with the Affordable Care Act (ACA) and the AlaskaCare Third Party Administrator’s (TPA) clinical coverage standards. Clinical coverage standards regarding preventive care are subject to change and are updated periodically. The current TPA (Aetna) follows the ACA requirements for coverage of preventive care services, though in some cases, at the recommendation of expert groups outside those defined by the ACA, Aetna’s coverage may be broader than the ACA requirements.

Preventive care would be covered with the following cost sharing provisions:

<b>In-Network</b>	<b>Out-of-Network*</b>
Deductible does not apply. 100% coinsurance.	\$150 deductible applies. 80% coinsurance. Not subject to the individual out-of-pocket maximum.

*\*If use of out-of-network provider is pre-certified, in-network cost sharing provisions apply.*

Covered preventive services include, but are not limited to, mammograms, Pap smears, prostate cancer screenings, vaccinations, wellness visits, colorectal cancer screenings, and lung cancer screenings. The specific services covered by the Plan will change over time as the recommendations are updated to reflect the most current research and evidence.

**4) Actuarial and Financial Impacts of Proposed Change**

The proposed change would increase the actuarial value of the Plan by 0.50%. The annual anticipated fiscal impact of this change is estimated to be approximately \$3,350,000 in additional claims costs. This change is anticipated to increase the healthcare Accrued Actuarial Liability associated with the Plan by approximately \$28.6 million.



Proposal Title	Expanded Preventive Coverage (R007)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1 <sup>st</sup> , 2022
Reviewed By	Retiree Health Plan Advisory Board
Review Date	September 9, 2021

## Contents

1) SUMMARY OF CURRENT STATE .....	2
2) OBJECTIVES .....	2
3) SUMMARY OF PROPOSED CHANGE .....	3
4) ANALYSIS.....	12
5) IMPACTS .....	13
Actuarial Impact   Increase 0.50% .....	13
Financial Impact   Annual Cost Increase ~\$3.35m .....	13
Member Impact   Enhancement.....	15
Operational Impact (DRB)   Neutral .....	15
Operational Impact (TPA)   Minimal .....	16
6) CONSIDERATIONS.....	16
Clinical Considerations.....	16
Provider Considerations .....	16
7) PROPOSAL RECOMMENDATIONS.....	17
DRB Recommendation.....	17
RHPAB Board Recommendation .....	17

## 1) Summary of Current State

The AlaskaCare Defined Benefit Retiree Health Plan (Plan) was first developed in 1975 and provides extensive and valuable benefits for retirees and their dependents necessary for *the diagnosis and treatment* of an injury or disease.<sup>1</sup> The Plan was not established as a preventive or ‘wellness’ plan. Plan coverage for preventive services that are used to screen individuals prior to symptoms being exhibited is limited to mammograms, Pap smears and Prostate Specific Antigen tests (to detect prostate cancer in males).<sup>2</sup>

One of the most common reoccurring complaints the Division of Retirement and Benefits (Division) receives is related to the retiree Plan’s lack of preventive care coverage. This lack of coverage impacts retirees and their dependents differently, depending on whether the member is eligible for Medicare.

Members who are under the age of 65 (U65) are particularly impacted by the lack of preventive coverage. U65 members generally do not qualify for Medicare coverage and the Plan is their primary insurance coverage. Because the Plan excludes most preventive services, U65 members typically must pay out of pocket for the entire cost of those services.

Members who are over the age of 65 (O65) are generally eligible for Medicare, which becomes their primary coverage. Their AlaskaCare coverage becomes secondary to Medicare. Because Medicare offers many preventive services at little or no cost to the beneficiary,<sup>3</sup> members covered by Medicare have coverage for many of these services.

In conjunction with the effective date of certain requirements in the Patient Protection and Affordable Care Act (ACA), insurance coverage for preventive care following age-specific guidelines indicating the utilization of screening and preventive services for older adults became required coverage in most health plans. Preventive services are intended to increase early detection and treatment of health conditions in order to improve clinical outcomes, arrest disease at an earlier stage when it is easier and more effectively treated, and to promote health-conscious behavior. As a retiree-only plan, the Plan is exempt from the ACA provisions mandating coverage for preventive care.

The lack of Plan coverage for most preventive benefits may result in U65 retirees foregoing recommended age-specific vaccinations, screenings, and other preventive services. It is also a source of significant dissatisfaction for new retirees who are used to having these services covered (typically with no member cost share) by their pre-retirement health care plan(s).

## 2) Objectives

- a) Support members in maintaining their health.
- b) Promote high-value care.

---

<sup>1</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021, Sec. 3.3.1(d) *Medically Necessary Services and Supplies*; and Sec. 5.1, *Limitations and Exclusions*.

<sup>2</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021, Sec. 3.3.11(a)-(d), *Radiation, X-rays, and Laboratory Tests*.

<sup>3</sup> Details regarding Medicare coverage and cost-sharing for preventive and screening services can be found here: <https://www.medicare.gov/coverage/preventive-screening-services>.

- c) Increase accessibility to patient care for non-emergency health episodes.

### 3) Summary of Proposed Change

The Division proposes adding the full suite of evidence-based preventive services to the Plan that mirror those provided in most employee plans in accordance with the Affordable Care Act.<sup>4</sup> These preventive services include, but are not limited to:

1. evidence based preventive services with an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF),<sup>5</sup>
2. standard vaccines recommended by the Advisory Committee on Immunization Practices (ACIP),<sup>6</sup>
3. preventive care for children recommended under the *Bright Futures* guidelines, developed by the American Academy of Pediatrics,<sup>7</sup>
4. women-specific preventive care as outlined by the USPSTF, the Health Resources & Services Guidelines (HRSA) and other evidence-based guidelines.<sup>8</sup>

The specific services covered by the Plan will change over time as the recommendations are updated to reflect the most current research and evidence.

In alignment with the Plan booklet, *Section 3.3.1 Medically Necessary Services and Supplies*,<sup>9</sup> and mainstream commercial health insurance practices, the Plan will utilize the current Third-Party Administrator’s (TPA) clinical coverage standards for purposes of determining coverage of preventive services under the Plan. Clinical coverage standards regarding preventive care are subject to change and are updated periodically. The current TPA (Aetna) follows the ACA requirements for coverage of preventive care services, though in some cases, at the recommendation of expert groups outside those defined by the ACA, Aetna’s coverage may be broader than the ACA requirements. If the Plan transitions to a different TPA in the future, that TPA’s ACA-compliant clinical standards will be utilized to determine coverage of preventive services under the Plan. This aligns with coverage offered under the AlaskaCare employee plan.

Aetna describes its clinical coverage standards in clinical policy bulletins (CPBs), which are all available online for public review.<sup>10</sup> Aetna’s CPBs are based on objective, creditable sources, such as relevant scientific literature, guidelines, consensus statements, and expert opinions. Aetna’s CPBs are reviewed at least once annually, or on an ad hoc basis as needed.

#### *Cost Sharing*

Based on consensus from the Retiree Health Plan Advisory Board (RHPAB) Modernization Subcommittee, the following member cost sharing structure for preventive services is proposed. The proposed cost share structure was labeled as “Option B” in earlier iterations of this proposal.

---

<sup>4</sup> <https://www.healthcare.gov/coverage/preventive-care-benefits/>

<sup>5</sup> <https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

<sup>6</sup> <https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

<sup>7</sup> <https://brightfutures.aap.org/Pages/default.aspx>

<sup>8</sup> <https://www.healthcare.gov/preventive-care-women/>

<sup>9</sup> <http://doa.alaska.gov/dr/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>

<sup>10</sup> Aetna’s clinical policy bulletins are available online: <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#>

Table 1. Proposed Cost Sharing Provisions

	Covered Preventive Services	Deductible	Coinsurance	Out-Of-Pocket Maximum
<b>Current</b>	Limited coverage for specific preventive services	\$150	80%	\$800; applies after the deductible is satisfied
<b>Proposed In Network</b>	Coverage for preventive services in alignment with the ACA and the TPA’s CPBs	N/A; deductible doesn’t apply	100%	N/A; in-network preventive services covered at 100%
<b>Proposed Out-of-Network</b>	Coverage for preventive services in alignment with the ACA the TPA’s CPBs	\$150	80%	No out-of-pocket maximum for preventive services

The proposed cost share structure would implement richer cost share provisions for preventive care received from network providers. The AlaskaCare deductible would not apply, and the plan would pay 100% coinsurance for covered services.<sup>11</sup>

For preventive care received from out-of-network providers, members would first have to meet the \$150 deductible, and then the plan would pay 80% coinsurance for covered services. Out-of-network preventive services would not be subject to the out-of-pocket maximum; the plan would continue to pay 80% coinsurance for any out-of-network preventive services received.

If there are no network provider options in a member’s area, the member may contact Aetna and request precertification of use of an out-of-network provider for preventive services. If this precertification is approved, the in-network cost sharing provisions (subject to recognized charge)<sup>12</sup> would apply and the plan would pay 100% of the cost for the preventive services (subject to recognized charge). If the out-of-network provider’s charge for the service is more than the recognized charge, the provider may bill the member for the “balance,” or amount above the recognized charge. If a provider issues a balance bill to the member, the member is responsible for paying that amount to the provider. Amounts above recognized charge are excluded as outlined under the AlaskaCare Retiree Insurance Information Booklet Section 5.1 *Limitations and Exclusions*.

This cost share structure is similar to most commercial plan standards including the AlaskaCare employee plan.

<sup>11</sup> In-network providers have agreed to a set of discounted negotiated rates for services provided. In-network providers have agreed not to bill members for any amount over these agreed-upon rates.

<sup>12</sup> For out-of-network providers, the recognized charge for medical services and supplies are the lesser of a) what the provider bills or submits for that service or supply; or b) the 90<sup>th</sup> percentile of the prevailing charge rate for the geographic area where the service is furnished as determined by Aetna in accordance with Aetna reimbursement policies. See Retiree Insurance Information Booklet, section 3.1.4 *Recognized Charge*.

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>

### Coordination with Medicare

The Plan would continue to coordinate with Medicare in accordance with the 2021 AlaskaCare Retiree Insurance Information Booklet, *Section 3.1.7, Effect of Medicare*.<sup>13</sup> In accordance with state statute, when a member reaches age 65, their AlaskaCare retiree plan benefits become supplemental to Medicare.

### Coverage Provisions

Table 2 highlights key preventive services and compares current Plan coverage, ACA-specified coverage, Medicare coverage, and Aetna’s policies regarding those services. The ACA-specified column represents current guidelines from the USPSTF, ACIP, and other relevant sources which are subject to change as those guidelines are updated. The Aetna Policy column is reflective of coverage for “preventive” care. Depending on a member’s specific condition, some services may be considered medically necessary under other circumstances or at different frequencies if provided under diagnostic circumstances or as treatment. Please note that some of the services included in Table 2 may be currently covered by the Plan if they are performed to aid in a diagnosis, rather than performed as a screening.

Table 2. Key Preventive Services Coverage Comparison

Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
<b>Mammograms</b>	One baseline between age 35-40. One every two years between age 40-50. Annually at age 50 and above and for those with a personal or family history of breast cancer.	<b>HRSA:</b> Annual screening for average-risk women 40 and older. <sup>18</sup>	One baseline between age 35-39. Screening mammograms once every 12 months age 40 or older. Diagnostic mammograms more frequently than once a year, if medically necessary.	Screening for women 40 years of age and older, once annually. <sup>19</sup>  <i>Annual mammography is also considered medically necessary for younger women who are judged to be high risk and meet certain criteria (may be considered diagnostic, not preventive).</i>

<sup>13</sup> <http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>

<sup>14</sup> These represent ACA-specified guidelines from the USPSTF, ACIP, and other relevant sources and are subject to change as those guidelines are updated.

<sup>15</sup> Unless otherwise noted, Medicare coverage in this table aligns with coverage descriptions provided at [www.Medicare.gov](http://www.Medicare.gov), accessed May 4, 2021.

<sup>16</sup> Aetna’s clinical policy bulletins outline medical necessity for all care, regardless of whether or not it is considered preventive. For services to be considered preventive, they must be billed with preventive-specific codes.

<sup>17</sup> Unless otherwise noted, Aetna standard policy for Preventive care aligns with coverage descriptions provided at <https://www.aetna.com/health-guide/preventive-care-by-age.html>, accessed July 12, 2021. Coverage descriptions assume appropriate diagnosis and procedure codes are submitted on the claim(s).

<sup>18</sup> Health Resources & Services Administration. Women’s Preventive Services Initiative. <https://www.hrsa.gov/womens-guidelines-2019>

<sup>19</sup> Aetna Clinical Policy Bulletin 0584, [https://www.aetna.com/cpb/medical/data/500\\_599/0584.html](https://www.aetna.com/cpb/medical/data/500_599/0584.html)

Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
<b>Pap Smear</b>	One per year for women 18 years of age and older. Also includes limited office visit to collect the pap smear.	<p><b>HRSA/USPSTF Grade A:</b> One every 3 years for women aged 21 to 65 for cervical cytology alone.<sup>20</sup></p> <p>One every 5 years for women aged 30 to 65 for HPV testing alone, or when cervical cytology is combined with HPV testing.<sup>21</sup></p>	One every 24 months. One every 12 months for those at high risk. HPV testing once every five years for women aged 30 to 65 without HPV symptoms.	<p>For women 21 years of age and older, once annually.</p> <p>HPV screening for women 30 years of age or older, once annually.<sup>22</sup></p>
<b>Prostate specific antigen (PSA)</b>	One annual screening test for men between ages 35 and 50 with a personal or family history of prostate cancer. One annual screening test for men 50 years and older.	<p><b>USPSTF Grade C:</b> Men ages 55 to 69, are encouraged to make an individual decision about prostate-specific antigen (PSA)-based cancer screening with their clinician.</p> <p><b>USPSTF Grade D:</b> Routine PSA screening for men age 70 and older is not recommended.<sup>23</sup></p>	Digital rectal exams and prostate specific antigen (PSA) blood tests once every 12 months for men over 50 (starting the day after your 50th birthday).	<p>For men 40 years of age and older, once annually.</p> <p>Prostate cancer screening via digital rectal exam is considered preventive for males 40 years of age and older, once annually.<sup>24</sup></p>

<sup>20</sup> Health Resources & Services Administration. Women’s Preventive Services Initiative. <https://www.hrsa.gov/womens-guidelines-2019>

<sup>21</sup> USPSTF, Cervical Cancer: Screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>

<sup>22</sup> Aetna Clinical Policy Bulletin 0443, [https://www.aetna.com/cpb/medical/data/400\\_499/0443.html](https://www.aetna.com/cpb/medical/data/400_499/0443.html)

<sup>23</sup> <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/prostate-cancer-screening1>

<sup>24</sup> Aetna Clinical Policy Bulletin 0521, [https://www.aetna.com/cpb/medical/data/500\\_599/0521.html](https://www.aetna.com/cpb/medical/data/500_599/0521.html).



Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
<b>Vaccines</b>	<p>Limited coverage for all members for vaccines covered by Medicare Part D through the pharmacy plan.</p> <p>Common vaccines include shingles, diphtheria, tetanus, measles-mumps-rubella (MMR), polio, hepatitis, and HPV.</p>	<p>Coverage for those recommended by ACIP. Recommended vaccine schedules are released for children 0-18 years and for adults age 19 and older.<sup>25</sup></p> <p>Common vaccines include hepatitis A &amp; B, HPV, flu, measles-mumps-rubella (MMR), meningitis, pneumonia, tetanus, diphtheria, pertussis, polio, chickenpox, rabies.</p>	<p>Flu, pneumonia, hepatitis B for persons at increased risk of hepatitis, COVID-19, vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus.<sup>26</sup></p>	<p>Coverage for those recommended by ACIP. Recommended vaccine schedules are released for children 0-18 years and for adults age 19 and older.</p> <p>Common vaccines include hepatitis A &amp; B, HPV, flu, measles-mumps-rubella (MMR), meningitis, pneumonia, tetanus, diphtheria, pertussis, polio, chickenpox, rabies.</p>
<b>Annual Wellness Visit</b>	Not Covered	Covered in conjunction with preventive services. <sup>27</sup>	“Welcome to Medicare” visit covered once within first 12 months of Medicare Part B coverage. Yearly wellness visits once every 12 months.	Covered once annually for adults over 18.

<sup>25</sup> See attachment E: <https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf> and attachment F: <https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf>

<sup>26</sup> How to pay for Vaccines: Medicare <https://www.cdc.gov/vaccines/adults/pay-for-vaccines.html>

<sup>27</sup> Preventive Care Benefits for Adults. HealthCare.gov. <https://www.healthcare.gov/preventive-care-adults/>

Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
<b>Well Woman Preventive Visits</b>	Not Covered (exception of limited exam to collect the pap smear)	Covered as outlined by the USPSTF and other evidence-based guidelines. <sup>28</sup> Commonly covered services include vaccinations, screening tests, and education & health counseling. <sup>29</sup>	Screening Pap tests, pelvic exams, and HPV screening once every 24 months. More frequently for those at high risk. <sup>30</sup>	Well Woman visits covered once annually.
<b>Well Child Preventive Visits</b>	Not Covered	Covered as outlined by the USPSTF and other evidence-based guidelines. <sup>31</sup> Commonly covered services include developmental screenings, physical examinations, behavioral assessments, blood screenings, hearing screenings, immunization vaccines.	Children under the age of 20 may only be eligible for Medicare in very limited circumstances. However, “Welcome to Medicare” visits are covered once within first 12 months of Medicare Part B coverage. Yearly wellness visits once every 12 months.	Children ages 0-12 months, seven preventive exams annually.  Children ages 1-3 years, three preventive exams annually.  Children 3 years of age and older, one preventive exam annually.

<sup>28</sup> Preventive Care Benefits for Women. HealthCare.gov. <https://www.healthcare.gov/preventive-care-women/>

<sup>29</sup> Get Your Well-Woman Visit Every Year. U.S. Department of Health and Human Services. <https://health.gov/myhealthfinder/topics/everyday-healthy-living/sexual-health/get-your-well-woman-visit-every-year>

<sup>30</sup> <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-papPelvic-Examinations.pdf>

<sup>31</sup> <https://www.healthcare.gov/preventive-care-children/>

Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
Colorectal Cancer Screening	Not Covered	<p><b>USPSTF Grade A:</b> Colorectal cancer screening recommended for all adults age 50-75. Frequency varies by type of screening.</p> <p><b>USPSTF Grade B:</b> Colorectal cancer screening recommended for all adults age 45-49. Frequency varies by type of screening.</p> <p><b>USPSTF Grade C:</b> Clinicians should selectively offer colorectal cancer screening for adults age 76-85, as appropriate based on an individual's specific circumstances.<sup>32</sup></p>	Screening colonoscopies covered once every 24 months if at high risk; or once every 120 months, or 48 months after a previous flexible sigmoidoscopy.	<p>Covered for adults 45 years of age and older. Frequency depends on colorectal cancer screening type.<sup>33</sup></p> <ul style="list-style-type: none"> <li>• Annual immunohistochemical or guaiac-based FOBT; or</li> <li>• Colonoscopy (every 10 years for persons at average risk); or</li> <li>• CT Colonography (virtual colonoscopy) (every 5 years); or</li> <li>• Double contrast barium enema (DCBE) (every 5 years for persons at average risk); or</li> <li>• Sigmoidoscopy (every 5 years for persons at average risk)</li> <li>• Sigmoidoscopy (every five years) with annual immunohistochemical or guaiac-based fecal occult blood testing (FOBT); or</li> <li>• Stool DNA (FIT-DNA, Cologuard) (every 3 years).</li> </ul>

<sup>32</sup> USPSTF, Colorectal Cancer: Screening: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>

<sup>33</sup> Aetna Clinical Policy Bulletin 0516, [https://www.aetna.com/cpb/medical/data/500\\_599/0516.html](https://www.aetna.com/cpb/medical/data/500_599/0516.html)

Service	Current Plan Coverage	ACA-Specified Guidelines <sup>14</sup>	Medicare Coverage <sup>15</sup>	Aetna Policy <sup>16,17</sup>
Lung Cancer Screening	Not Covered	USPSTF Grade B: Annual screening recommended in adults aged 50 to 80 who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years.	Covered once annually for asymptomatic adults age 55-77 who have a 30 pack-year smoking history and are current smokers or have quit within the last 15 years.	For current or former smokers ages 50 to 80 with a 20 pack-year smoking history (if a former smoker, has quit within the past 15 years), once annually. <sup>34</sup>

*\*Table 2 highlights coverage provisions for key services. This table is not a complete and exhaustive list of ACA preventive service coverage mandates, or preventive service coverage provisions. Please refer to relevant guidelines for complete and exhaustive coverage provisions.*

### Screening vs. Diagnostic Services

Services are considered preventive care when the person receiving care:

- does not have any symptoms, or tests or studies indicating an abnormality at the time the service is provided;
- has had a screening done in accordance with the relevant clinical guidelines and the results were considered normal;
- has had a diagnostic service with normal results, after which the physician recommends future preventive care screenings using the appropriate normal age and gender recommendations contained in the relevant clinical guidelines; or
- has a preventive service done that results in a diagnostic service being done at the same time, because it is an integral part of the preventive service (e.g., polyp removal during a preventive colonoscopy).

If a health condition is diagnosed during a preventive care exam or screening, the provider may use a specific billing code to indicate that the exam or screening was preventive, and though it resulted in a diagnosis it should still qualify as preventive care and the claim will be paid according to the relevant preventive care cost-share provisions.

Services are considered diagnostic care (not preventive care) when:

- abnormal results on a previous preventive or diagnostic screening test requires further diagnostic testing or services;
- abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the appropriate normal age and gender recommendations contained in the relevant clinical guidelines;
- services are ordered due to current symptom(s) that require further diagnosis.

<sup>34</sup> Aetna Clinical Policy Bulletin 0380, [http://www.aetna.com/cpb/medical/data/300\\_399/0380.html](http://www.aetna.com/cpb/medical/data/300_399/0380.html)

*Example:*

Colorectal cancer screenings may be covered as preventive or diagnostic depending on individual circumstances reflected in the information provided with the claim. A colorectal cancer screening provided to an asymptomatic person who meets guidelines for screening will typically be considered a preventive service. A follow-up to an abnormal screening, or a screening administered because a member is having symptoms (e.g., rectal bleeding, unintentional weight loss, or anemia) will typically be considered diagnostic. Both preventive and diagnostic screenings can produce “baseline” results. The term “baseline” typically refers to initial results, rather than follow-up action.<sup>35</sup>

Colorectal cancer screenings include different types of tests (e.g., stool-based tests such as stool DNA tests, or direct visualization tests such as colonoscopies). There is no hard evidence to support any one of the colon cancer screening methodologies over another when screening individuals of average risk.

If preventive coverage is added, Aetna will process colorectal cancer screening claims according to how the claim is billed and coded. For example:

1. **What happens if a polyp is found?** Preventive screenings that identify a condition or abnormality (e.g., a colonoscopy that finds a polyp) are still billed as preventive screenings. Typically, providers will add a procedure code modifier to the claim to indicate that the preventive service became diagnostic based on their findings. For instance, modifier ‘PT’ identifies a colorectal cancer screening test that converted to a diagnostic test or other procedure. If modifier PT is present on the claim, then the associated codes are considered (and billed as) preventive screenings, even though a diagnosis resulted from the test.
2. **What happens if the claim is submitted with a non-preventive diagnosis code?** The claim would be considered as a diagnostic service and would be subject to normal deductible, coinsurance, and out-of-pocket maximums. If the service was truly preventive (e.g., the member received a colonoscopy and had never had a previous preventive colonoscopy), members can contact the Aetna concierge to request the claim be reprocessed as preventive.
3. **What if a person has a family history of colorectal cancer?** This would typically be reflected in the diagnosis code submitted with the claim. When this occurs, associated claims are typically considered diagnostic services, not preventive. However, if no previous preventive claims were paid, the claim in question may be eligible for coverage as a preventive service.
4. **What about follow-up colorectal cancer screenings?** Any additional tests would be considered based on the diagnosis code that is billed. If the diagnosis code indicates the service is diagnostic, the claim will be subject to normal deductible, coinsurance, and out-of-pocket maximums.

Actuarial Impact | Increase 0.50%  
Financial Impact | Annual Cost Increase \$3.35m  
Member Impact | Enhancement  
Operational Impact (DRB) | Neutral  
Operational Impact (TPA) | Minimal

---

<sup>35</sup> Baseline results could refer to either well or ill results.

## 4) Analysis

Screening tests look for a disease before a person exhibits symptoms, while preventive care services are meant to prevent diseases or conditions from developing or progressing. Adding coverage for preventive care services and screenings to the AlaskaCare defined benefit retiree health plan is anticipated to increase the use of preventive services and to support members in maintaining their health.

Screenings and preventive services can help prevent or detect diseases early, when the disease is easier to treat. For example, colorectal cancer nearly always develops from abnormal, precancerous growths. Screening tests can identify these growths before they become cancerous or before they progress to later stages of the disease, and they can be removed before they progress. Approximately 90% of new cases of colorectal cancer occur in people over the age of 50, making colorectal cancer screenings an important and valuable benefit for a retiree population.<sup>36</sup>

The United States Department of Health and Human Services (DHHS) outlines increasing the use of various preventive care services as key objectives in their Healthy People 2030 framework.<sup>37</sup> These objectives include increasing the proportion of the population who receive preventive services and who are screened for cancer including lung, breast, cervical and colon cancer. A 2009 joint report by the Centers for Disease Control and Prevention, the AARP, and the American Medical Association specifically highlights the importance of preventive care for individuals age 50 to 64 years of age and the difference in screenings provided to individuals who have insurance coverage versus those who do not have insurance coverage.<sup>38</sup>

Currently, data regarding retiree member's use of preventive visits outside of those currently covered by the plan (e.g. mammograms or PSA testing) is limited as retirees may be receiving these services and paying for them out of pocket. O65 members are likely receiving more preventive visits due to Medicare's coverage, but those visits are typically not captured in AlaskaCare's claims data. However, when comparing the prevalence of preventive visits based on the AlaskaCare active employee plan and the AlaskaCare retiree plan claims data there are striking differences between the plans. Figures 1 and 2 reflect prevalence of preventive visits for males and females between the AlaskaCare retiree and active employee plans as reflected in AlaskaCare claims data from May of 2019 through April of 2021.

---

<sup>36</sup> Colorectal (Colon) Cancer. US Centers for Disease Control and Prevention. [https://www.cdc.gov/cancer/colorectal/basic\\_info/screening/index.htm](https://www.cdc.gov/cancer/colorectal/basic_info/screening/index.htm)

<sup>37</sup> Healthy People 2030. US DHSS. <https://health.gov/healthypeople/objectives-and-data/browse-objectives/preventive-care>

<sup>38</sup> Promoting Preventive Services for Adults 50-64: Community and Clinical Partnerships. CDC, AARP, AMA, <https://www.cdc.gov/aging/pdf/promoting-preventive-services.pdf>

Figure 1. AlaskaCare Retiree Plan (U65 and O65)  
Preventive Visit Claims

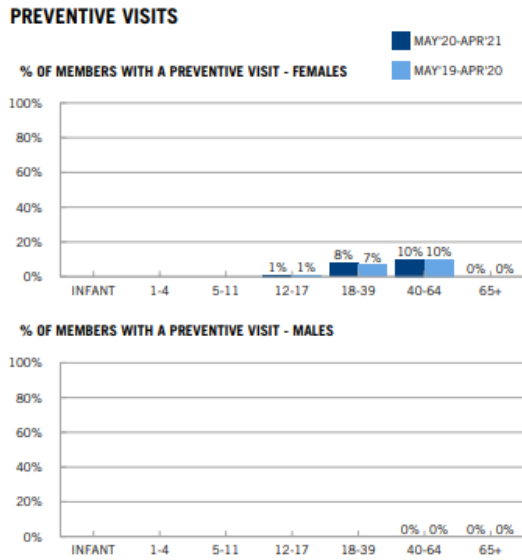
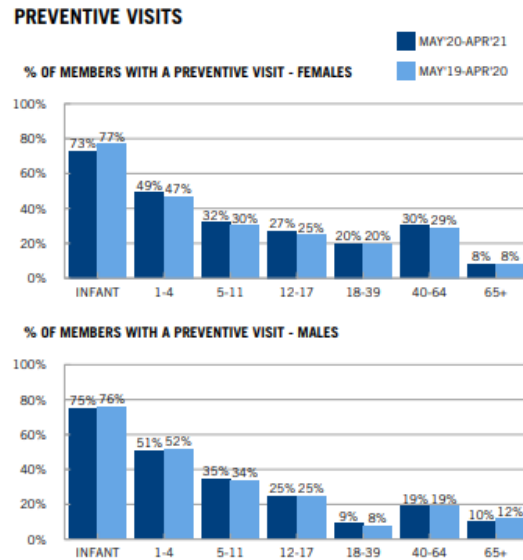


Figure 2. AlaskaCare Active Employee Plan  
Preventive Visit Claims



Expanding preventive care coverage to the AlaskaCare retiree plan is anticipated to increase member’s use of these important services, support early detection of disease, and prevent disease progression.

## 5) Impacts

### Actuarial Impact | Increase 0.50%

Expanding the scope of covered preventive services to align with the benefit coverage mandated by the ACA would increase the actuarial value of the plan by 0.50%. See Table 3 for details.

Table 3. Actuarial Impact

	Actuarial Impact
<b>Current</b>	N/A
<b>Proposed Expanded Preventive Care Coverage</b>	0.50% increase <sup>39</sup>
<u>In-Network:</u>	<u>Out-of-Network</u>
-100% coinsurance	-80% coinsurance
-deductible does not apply	-deductible applies
-out-of-pocket limit N/A	-out-of-pocket limit N/A

### Financial Impact | Annual Cost Increase ~\$3.35m

#### Potential Future Claims Impact

Coverage for preventive screenings does not necessarily result in plan savings as articulated by the Robert Wood Johnson Foundation in their 2009 study.<sup>40</sup> They found high-risk groups often stay away from

<sup>39</sup> *Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan* (Updated), Segal Consulting memo dated April 19, 2021.

<sup>40</sup> Goodell, S., Cohen, J., & Neumann, P. (2009, Sep 1). Cost Savings and Cost-Effectiveness of Clinical Preventive Care. Retrieved from <https://www.rwjf.org/en/library/research/2009/09/cost-savings-and-cost-effectiveness-of-clinical-preventive-care.html>.

screenings,<sup>41</sup> and health-conscious members may use the screenings in excess. The result is higher procedure volume and total costs without the net savings associated with early detection or treatment.

“It is unlikely that substantial cost savings can be achieved by increasing the level of investment in clinical preventive care measures. On the other hand, research suggests that many preventive measures deliver substantial health benefits given their costs.

Moreover, while the achievement of cost savings is beneficial, it is important to keep in mind that the goal of prevention, like that of other health initiatives, is to improve health. Even those interventions that cost more than they save can still be desirable. Because health care resources are finite, however, it is useful to identify those interventions that deliver the greatest health benefits relative to their incremental costs.”<sup>42</sup>

### **Annual Cost Impact**

Based on Segal Consulting’s preliminary retiree claims projection of \$633,000,000 for 2021 and trended forward at 6% for 2022, the annual anticipated fiscal impact of this change is estimated to be approximately \$3,350,000 in additional costs.<sup>43</sup>

Medicare covers many preventive and screening services at 100%. For Medicare-eligible members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible. The analysis considers the financial impacts associated with the approximately 21,000 members under the age of 65 and not yet eligible for Medicare.

### **Projected Long-Term Financial Impacts**

The annual cost increase associated with the proposed benefit additions may have long-term impacts to the healthcare Actuarial Accrued Liability (AAL)<sup>44</sup> and to the Additional State Contributions (ASC)<sup>45</sup> associated with the Plan. These impacts are somewhat tempered because the additional costs are primarily associated with the U65 retiree population, and because the total number of potential future participants is finite.

In an illustrative example, if the proposed changes had been reflected in the June 30, 2020 valuations, the AAL would have increased by approximately \$28.6 million, and the ASC for Fiscal Year (FY) 2023 would have increased by approximately \$400,000.<sup>46</sup>

---

<sup>41</sup> Benson WF and Aldrich N, CDC Focuses on Need for Older Adults to Receive Clinical Preventive Services, Critical Issue Brief, Centers for Disease Control and Prevention, 2012, <http://www.chronicdisease.org/nacdd-initiatives/healthy-aging/meeting-records>.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

<sup>44</sup> AAL: The excess of the present value of a pension fund’s total liability for future benefits and fund expenses over the present value of future normal costs for those benefits.

<sup>45</sup> Employer contributions to retirement payments were capped in FY08. Since then, the state makes additional assistance contributions to help cover the accrued unfunded liability associated with participating employers.

<sup>46</sup> *Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan*, Buck Consulting, May 7, 2021.



The ASC provides payment assistance to participating employers' Actuarially Determined Contribution (ADC). The ADC is determined by adding the "Normal Cost"<sup>47</sup> to the amount needed to offset the amortization of any existing unfunded accrued liability over a period of 25 years.

The illustrative increase to the FY23 ASC is associated with the Normal Cost only. The current overfunded status<sup>48</sup> of the retiree health care liabilities has eliminated the immediate need for amortization payments to offset any health care unfunded liability. It is important to note that the long-term funded status of the trusts is subject to change in response to market volatility and many other factors.

If the retiree health care liabilities were not overfunded, in accordance with the Alaska Retirement Management Board's (ARMB) current funding policy, the total illustrative increase in the FY23 ASC would be approximately \$2.3 million.<sup>49</sup>

## Member Impact | Enhancement

Neutral / Enhancement / Diminishment

Studies suggest that increasing coverage for preventive care may increase the use of preventive services by members. As noted above, most members over the age of 65 receive coverage for preventive services through Medicare, but many of those members have dependents covered by the plan who are not yet Medicare-eligible. This proposed change will be an added benefit for all members, providing access to preventive care previously excluded under the retiree health plan which members may be currently paying for in full.

As an example, colorectal cancer screenings can be some of the more expensive preventive services. The USPSTF guidelines recommend colorectal cancer screenings for adults starting at age 45. The AlaskaCare retiree plan has approximately 18,000 members between the ages of 45-64 who would benefit from expanded coverage for colorectal cancer screenings. Colorectal cancer screenings are a covered benefit under Medicare for which most retirees aged 65 and above are eligible.

The Division regularly receives feedback from members about the lack of preventive coverage in the plan, and the addition of these services is something the Division believes members will find both valuable and beneficial.

## Operational Impact (DRB) | Neutral

To implement this change, the Division will need to make updates to the AlaskaCare Retiree Insurance Information Booklet. These booklet changes will be provided to the public to review and to comment on prior to the 2022 plan year. Sample plan language outlining coverage for preventive services is attached.

---

<sup>47</sup> The normal cost represents the present value of benefits earned by active employees during the current year. The employer normal cost equals the total normal cost of the plan reduced by employee contributions.

<sup>48</sup> Due in part to the savings realized as a result of the 2019 implementation of the enhanced Employer Group Waiver Program (EGWP) group Medicare Part D prescription drug program, the retiree health care liabilities are currently overfunded. The Division's 2020 draft Actuarial Valuation Reports for the Public Employees' Retirement System (PERS) and the Teachers' Retirement System (TRS) indicate that the PERS actuarial funded ratio is 113.5% and the TRS actuarial funded ratio is 121.4%.

<sup>49</sup> *Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan*, Buck Consulting, May 7, 2021.

**\*\*Note:** this language is not the final proposed language for inclusion in the AlaskaCare retiree health plan; it is meant to only serve as an example. **\*\***

The Division anticipates the expansion of preventive benefits in the retiree health plan will reduce calls, complaints and appeals to the Division related to lack of preventive coverage.

The retiree health plan is an antiquated plan design and is unusual in its lack of coverage for most preventive services. For this reason, there is a substantial communication and education need for the Division to notice members regarding the lack of preventive services. That need would no longer exist if the benefits were expanded.

## **Operational Impact (TPA) | Minimal**

Using the TPA's CPBs to determine what services are covered, the impact to the TPA is minimal. The TPA would need to update and test the coding in their claims adjudication system to ensure that the claims are processed correctly. This is often a "yes/no" indicator switch in a TPA's claims adjudication system. The change would simplify the administration of the AlaskaCare retiree health plan, which currently requires customization to provide the limited preventive services covered by the plan today.

Similarly, it is industry standard to have a separate network/out-of-network coinsurance for preventive services and therefore will not require any customization. The TPA's customer service staff will need to be trained to address requests from retiree members who do not have access to a network provider in their area. However, similar network access provisions currently exist in the AlaskaCare employee plan, so the staff are already familiar with the process.

Last, offering the full suite of preventive services allows greater flexibility in disease management and broader communication options when there is not a concern about recommending a service not covered under the health plan.

## **6) Considerations**

### **Clinical Considerations**

It is largely agreed that the recommended preventive services can help detect disease, delay their onset, or identify them early on when the disease is most easy to manage or treat. Adding these services could have a positive clinical impact.

An example is colorectal cancer screenings. Excluding skin cancers, colorectal cancer is the third most common cancer diagnosed in both men and women. Screening can prevent colorectal cancer by finding and removing precancerous polyps before they develop into cancer. The cost of treatment is often lowest, and the survivor rates are better, when the tumor is found in the earlier stages.

### **Provider Considerations**

The Division expects that expanding preventive coverage will have a positive impact on providers. They may gain customers in members who previously would have forgone the non-covered services, and they should see ease in administration in that they will not need to bill the member directly for the non-covered services.

The coinsurance differential may incentivize some doctors to join the network, as many members may look for a network provider to maximize their health plan benefits.

## 7) Proposal Recommendations

### Summary

Add the full suite of evidence-based preventive services in alignment with the Affordable Care Act and the AlaskaCare TPA’s clinical coverage standards; implement the following cost sharing provisions:

In-Network	Out-of-Network
Deductible does not apply. 100% coinsurance.	\$150 deductible applies. 80% coinsurance. Not subject to the individual out-of-pocket maximum.  <i>If use of out-of-network provider is pre-certified, in-network cost sharing provisions apply.</i>

### DRB Recommendation

The Division of Retirement and Benefits recommends implementation of this proposal, effective January 1, 2022.

### RHPAB Board Recommendation

Insert the RHPAB recommendation here when final along with any appropriate comments.

Description	Date
Proposal Drafted	07/20/2018
Reviewed by Modernization Subcommittee	08/10/2018, 09/28/2018, 10/30/2018, 04/23/2019, 06/12/2019, 06/18/2021, 07/28/2021
Reviewed by RHPAB	08/29/2018, 11/28/2018, 02/06/2019, 05/08/2019, 08/07/2019, 05/13/2021, 08/05/2021, 09/09/2021

### Documents attached include:

Attachment	Document Name
A	<i>Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan (Updated)</i> , Segal Consulting memo dated April 19, 2021
B	<i>Impact of Potential Change in Preventive Care Benefits for AlaskaCare Retiree Health Plan</i> , Buck Consulting, May 7, 2021.
C	Sample Preventive Care Plan Language: Aetna Fully Insured Preventive Service Booklet Language 2021
D	A and B Recommendations   United States Preventive Services Taskforce   2021
E	Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, 2021

<b>F</b>	Recommended Adult Immunization Schedule for Ages 19 Years or Older, 2021
<b>G</b>	Aetna Presentation, <i>Preventive Care</i> , June 18, 2021

## Memorandum

**To:** Ajay Desai, Director, Division of Retirement and Benefits

**From:** Richard Ward, FSA, FCA, MAAA

**Date:** April 19, 2021

**Re:** Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan (*Updated*)

The AlaskaCare Retiree Plan currently provides coverage for some select preventive benefits. Currently, the Plan provides coverage for the following routine lab tests:

- One pap smear per year for all women age 18 or older. Charges for a limited office visit to collect the pap smear are also covered.
- Prostate specific antigen (PSA) tests as follows:
  - One annual screening PSA test for men between ages 35 and 50 with a personal or family history of prostate cancer, and
  - One annual screening PSA test for men 50 years and older
- Mammograms as follows:
  - One baseline mammogram between age 35 and 40
  - One mammogram every two years between ages 40 and 50, and
  - One annual mammogram at age 50 years and above, and for those with a personal or family history of breast cancer.

Coverage is provided in the same manner that other medical treatments and services are covered. The Plan applies the general plan provisions, such as deductible, coinsurance and out-of-pocket limitations, to determine any portion of the costs that are the member's responsibility. If the member has additional coverage, such as Medicare or other employer provided coverage, any portion of the costs covered by that plan is also considered.

Below is a table outlining the current benefits offered under the Plan:

<b>Deductibles</b>		
Annual individual / family unit deductible	\$150 / up to 3x per family	
<b>Coinsurance</b>		
Most medical expenses	80%	
Most medical expenses after out-of-pocket limit is satisfied	100%	
Second surgical opinions, Preoperative testing, Outpatient testing/surgery	100%	
• No deductible applies		
<b>Out-of-Pocket Limit</b>		
Annual individual out-of-pocket limit	\$800	
• Applies after the deductible is satisfied		
• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit		
<b>Benefit Maximums</b>		
Individual lifetime maximum	\$2,000,000	
• Prescription drug expenses do not apply against the lifetime maximum		
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430	
<b>Prescription Drugs</b>		Up to 90 Day or 100 Unit Supply
	Generic	Brand Name
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0

A change to the benefits under consideration would align the scope of benefits with those required of non-Grandfathered plans under the Affordable Care Act (ACA). Note that retiree plans, such as the AlaskaCare Retiree Plan, are not subject to the same provisions under the ACA that apply to the AlaskaCare Employee Plan. The changes to preventive benefits have been analyzed in the following two ways:

- A. Option A: In-Network: 80% coinsurance/deductible applies/out-of-pocket limit applies; Out-of-Network: 60% coinsurance/deductible applies/out-of-pocket limit does not apply.
- B. Option B: In-Network: 100% coinsurance/deductible does not apply; Out-of-Network: 80% coinsurance/deductible applies/out-of-pocket limit does not apply.

## Actuarial Value

Our updated analysis utilizes claims data and the Optum Comprehensive Benefit Pricing Model<sup>1</sup>, along with previously completed work using the Apex Actuarial Rate Modeling System<sup>2</sup>.

The impact of expanding the scope of covered services to align the scope of benefits with those required of non-Grandfathered plans under the ACA while being subject to deductibles, coinsurance and other plan provisions (Option A) would increase the actuarial value by 0.45%<sup>3</sup>.

The impact of expanding the scope of covered services to align the scope of benefits with those required of non-Grandfathered plans under the ACA at no member cost, 100% plan paid, for network provided services (Option B), would be an increase of 0.50% in actuarial value.<sup>4</sup>

The updated analysis reflects additional anticipated utilization resulting from the expanded benefits. For Medicare members, many of these services, including colonoscopies, are currently covered at 100% by Medicare. For these members, no change in utilization is assumed and the impact on the Plan is anticipated to be negligible.

## Financial Impact

Based on the most recent retiree medical and pharmacy claims projection of \$633,000,000 for 2021 (dated August 28, 2020), and trended forward at 6% to \$670,000,000 for 2022, this equates to approximately \$3,000,000 (Option A) to \$3,350,000 (Option B) in additional annual costs to the Plan depending on the cost sharing provisions.

## Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is

<sup>1</sup> The Optum Comprehensive Benefit Pricing Model provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal held an annual license to utilize this model at the time the analysis was conducted.

<sup>2</sup> The Apex Actuarial Rate Modeling System provides comprehensive plan design and rate modeling capabilities, and is widely utilized throughout the industry by insurance carriers and consulting actuaries. Segal held an annual license to utilize this model at the time the analysis was conducted.

<sup>3</sup> The previous analysis did not review the actuarial value change for a plan benefit that was subject to deductibles, coinsurance and other plan provisions.

<sup>4</sup> The previous analysis included in the July 25, 2018 Preventive Care Benefits – Focus on Actuarial and Financial Impact for the Retiree Plan memo provide an actuarial value change of 0.75%.

referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

The Coronavirus (COVID-19) pandemic is rapidly evolving and will likely impact the 2021 US economy and health plan claims projections for most Health Plan Sponsors. As a result, projections could be significantly altered by emerging events. At this point, it is unclear what the impact will be for Health Plan Sponsors. Segal continues to develop and review plan cost adjustment factors and reports to apply to both short-term and long-term financial projections. Additionally, the potential for federal or state fiscal relief is also not contemplated in these budget projections.

cc: Emily Ricci, Division of Retirement and Benefits  
Betsy Wood, Division of Retirement and Benefits  
Andrea Mueca, Division of Retirement and Benefits  
Noel Cruse, Segal  
Eric Miller, Segal  
Quentin Gunn, Segal



## Preventive care and wellness

This section describes the **eligible health services** and supplies available under your plan when you are well.

### Important notes:

1. You will see references to the following recommendations and guidelines in this section:
  - Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
  - United States Preventive Services Task Force
  - Health Resources and Services Administration
  - American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the Calendar Year, one year after the updated recommendation or guideline is issued.

2. Diagnostic testing will not be covered under the preventive care benefit. For those tests, you will pay the cost sharing specific to **eligible health services** for diagnostic testing.
3. Gender- specific preventive care benefits include **eligible health services** described below regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.
4. To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact your **physician** or contact Member Services by logging on to your Aetna member website at [www.aetna.com](http://www.aetna.com) or calling the number on your ID card. This information can

also be found at the [www.HealthCare.gov](http://www.HealthCare.gov) website.

## Routine physical exams

**Eligible health services** include office visits to your **physician, PCP** or other **health professional** for routine physical exams. This includes routine vision and hearing screenings given as part of the exam. A routine exam is a medical exam given by a **physician** or other **health professional** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - Screening for gestational diabetes for women
  - High risk human papillomavirus (HPV) DNA testing for women age 30 and older
- Radiological services, lab and other tests given in connection with the exam.
- For covered children, from birth to age 2:
  - An initial hospital checkup
  - Periodic well child exams
  - Consultation between the **health professional** and a parent

## Newborn hearing screening exam

**Eligible health services** include:

- Screening test for hearing loss prior to the date the child is 30 days old and
- Diagnostic hearing evaluation if the initial screening test shows the child may have a hearing impairment.

## Preventive care immunizations

**Eligible health services** include immunizations for infectious diseases recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Your plan does not cover immunizations that are not considered preventive care, such as those required due to your employment or travel.

## Well woman preventive visits

**Eligible health services** include your routine:

- Well woman preventive exam office visit to your **physician, PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN. This includes pap smears. Your plan covers the exams recommended by the Health Resources and Services Administration. A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**.
- Preventive care breast cancer (BRCA) gene blood testing by a **physician** and lab.
- Preventive breast cancer genetic counseling provided by a genetic counselor to interpret the test results and evaluate treatment.

## Preventive screening and counseling services

**Eligible health services** include screening and counseling by your **health professional** for some conditions. These are obesity, misuse of alcohol and/or drugs, use of tobacco products, sexually transmitted infection counseling and genetic risk counseling for breast and ovarian cancer. Your plan will cover the services you get in an individual or group setting. Here is more detail about those benefits.

- **Obesity and/or healthy diet counseling**

**Eligible health services** include the following screening and counseling services to aid in weight reduction due to obesity:

- Preventive counseling visits and/or risk factor reduction intervention
- Nutritional counseling
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease

- **Misuse of alcohol and/or drugs**

**Eligible health services** include the following screening and counseling services to help prevent or reduce the use of an alcohol agent or controlled substance:

- Preventive counseling visits
- Risk factor reduction intervention
- A structured assessment

- **Use of tobacco products**

**Eligible health services** include the following screening and counseling services to help you to stop the use of tobacco products:

- Preventive counseling visits
- Treatment visits
- Class visits;
- Tobacco cessation prescription and over-the-counter drugs
  - **Eligible health services** include FDA- approved **prescription drugs** and over-the-counter (OTC) drugs to help stop the use of tobacco products, when prescribed by a **prescriber** and the **prescription** is submitted to the pharmacist for processing.

Tobacco product means a substance containing tobacco or nicotine such as:

- Cigarettes
- Cigars
- Smoking tobacco
- Snuff
- Smokeless tobacco
- Candy-like products that contain tobacco

- **Sexually transmitted infection counseling**

**Eligible health services** include the counseling services to help you prevent or reduce sexually transmitted infections.

- **Genetic risk counseling for breast and ovarian cancer**

**Eligible health services** include counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.

## Routine cancer screenings

**Eligible health services** include the following routine cancer screenings:

- Mammograms
- Prostate specific antigen (PSA) tests
- Digital rectal exams
- Fecal occult blood tests
- Sigmoidoscopies
- Double contrast barium enemas (DCBE)
- Colonoscopies which includes removal of polyps performed during a screening procedure, and a pathology exam on any removed polyps
- Lung cancer screenings

These benefits will be subject to any age, family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration
- Found in the American Cancer Society guidelines for colorectal cancer screening

**Eligible health services** include:

- A mammogram for women:
  - With a history of breast cancer
  - Who have a parent or sibling with a history of breast cancer
  - Who have received a referral from a **physician**
- Additional cancer screenings at frequencies that may not be included in the guidelines referenced above. See your schedule of benefits for details.

## Prenatal care

**Eligible health services** include your routine prenatal physical exams, which is the initial and subsequent history and physical exam such as:

- Maternal weight
- Blood pressure
- Fetal heart rate check
- Fundal height

You can get this care at your **physician's, PCP's, OB's, GYN's, or OB/GYN's** office.

### **Important note:**

You should review the benefit under *Eligible health services under your plan- Maternity and related newborn care* and the *Exceptions* sections of this booklet-certificate for more information on coverage for pregnancy expenses under this plan.

## Comprehensive lactation support and counseling services

**Eligible health services** include comprehensive lactation support (assistance and training in breast feeding) and counseling services during pregnancy or at any time following delivery for breast feeding. Your plan will cover this when you get it in an individual or group setting. Your plan will cover this counseling only when you get it from a certified lactation support **provider**.

## Breast feeding durable medical equipment

**EXAMPLE PLAN LANGUAGE – NOT PROPOSED FOR INCLUSION IN THE ALASKACARE RETIREE HEALTH PLAN**

**Eligible health services** include renting or buying **durable medical equipment** you need to pump and store breast milk as follows:

**Breast pump**

**Eligible health services** include:

- Renting a **hospital** grade electric pump while your newborn child is confined in a **hospital**.
- The buying of:
  - An electric breast pump (non-**hospital** grade). Your plan will cover this cost once every three years, or
  - A manual breast pump. Your plan will cover this cost once per pregnancy.

If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.

**Breast pump supplies and accessories**

**Eligible health services** include breast pump supplies and accessories. These are limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

**Family planning services – female contraceptives**

**Eligible health services** include family planning services such as:

**Counseling services**

**Eligible health services** include counseling services provided by a **physician**, OB, GYN, or OB/GYN on contraceptive methods. These will be covered when you get them in either a group or individual setting.

**Devices**

**Eligible health services** include contraceptive devices (including any related services or supplies) when they are provided by, administered or removed by a **physician** during an office visit.

**Voluntary sterilization**

**Eligible health services** include charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

**Important note:**

EXAMPLE PLAN LANGUAGE – NOT PROPOSED FOR INCLUSION IN THE ALASKACARE RETIREE HEALTH PLAN

See the following sections for more information:

- *Family planning services - other*
- *Maternity and related newborn care*
- *Outpatient prescription drugs*
- *Treatment of basic infertility*

EXAMPLE

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked	The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.	B	December 2019 *
Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening: adults aged 40 to 70 years who are overweight or obese	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	October 2015 *
Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer: Preventive Medication: adults aged 50 to 59 years with a 10% or greater 10-year cvd risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease (CVD) and colorectal cancer (CRC) in adults aged 50 to 59 years who have a 10% or greater 10-year CVD risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B	April 2016 *
Asymptomatic Bacteriuria in Adults: Screening: pregnant persons	The USPSTF recommends screening for asymptomatic bacteriuria using urine culture in pregnant persons.	B	September 2019 *
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation	The USPSTF recommends that primary care clinicians assess women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or who have an ancestry associated with breast cancer susceptibility 1 and 2 (BRCA1/2) gene mutations with an appropriate brief familial risk assessment tool. Women with a positive result on the risk assessment tool should receive genetic counseling and, if indicated after counseling, genetic testing.	B	August 2019 *
Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older	The USPSTF recommends that clinicians offer to prescribe risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, to women who are at increased risk for breast cancer and at low risk for adverse medication effects.	B	September 2019 *

Breast Cancer: Screening: women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years. †	B	January 2016 *
Breastfeeding: Primary Care Interventions: pregnant women, new mothers, and their children	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	B	October 2016 *
Cervical Cancer: Screening: women aged 21 to 65 years	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). See the Clinical Considerations section for the relative benefits and harms of alternative screening strategies for women 21 years or older.	A	August 2018 *
Colorectal Cancer: Screening: adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies.	A	June 2016 *
Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.	B	May 2014 *
Dental Caries in Children from Birth Through Age 5 Years: Screening: children from birth through age 5 years	The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.	B	May 2014 *
Depression in Adults: Screening: general adult population, including pregnant and postpartum women	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	January 2016 *
Depression in Children and Adolescents: Screening: adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	February 2016 *



Falls Prevention in Community-Dwelling Older Adults: Interventions: adults 65 years or older	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	B	April 2018 *
Folic Acid for the Prevention of Neural Tube Defects: Preventive Medication: women who are planning or capable of pregnancy	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	January 2017 *
Gestational Diabetes Mellitus, Screening: asymptomatic pregnant women, after 24 weeks of gestation	The USPSTF recommends screening for gestational diabetes mellitus (GDM) in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Chlamydia and Gonorrhea: Screening: sexually active women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B	September 2014 *
Chlamydia and Gonorrhea: Screening: sexually active women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.	B	September 2014 *
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults With Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity.	B	November 2020 *
Screening for Hepatitis B Virus Infection in Adolescents and Adults: adolescents and adults at increased risk for infection	The USPSTF recommends screening for hepatitis B virus (HBV) infection in adolescents and adults at increased risk for infection. See the Practice Considerations section for a description of adolescents and adults at increased risk for infection.	B	December 2020 *
Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit	A	July 2019 *

Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years	The USPSTF recommends screening for hepatitis C virus (HCV) infection in adults aged 18 to 79 years.	B	March 2020 *
Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults aged 15 to 65 years. Younger adolescents and older adults who are at increased risk of infection should also be screened. See the Clinical Considerations section for more information about assessment of risk, screening intervals, and rescreening in pregnancy.	A	June 2019 *
Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons	The USPSTF recommends that clinicians screen for HIV infection in all pregnant persons, including those who present in labor or at delivery whose HIV status is unknown.	A	June 2019 *
Screening for Hypertension in Adults: adults 18 years or older without known hypertension	The USPSTF recommends screening for hypertension in adults 18 years or older with office blood pressure measurement (OBPM). The USPSTF recommends obtaining blood pressure measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	April 2021 *
Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening: women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services. See the Clinical Considerations section for more information on effective ongoing support services for IPV and for information on IPV in men.	B	October 2018 *
Latent Tuberculosis Infection: Screening: asymptomatic adults at increased risk for infection	The USPSTF recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk.	B	September 2016 *
Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication : pregnant women who are at high risk for preeclampsia	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014

Lung Cancer: Screening: adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	March 2021 *
Obesity in Children and Adolescents: Screening: children and adolescents 6 years and older	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B	June 2017 *
Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.	A	January 2019 *
Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. See the Clinical Considerations section for information on risk assessment.	B	June 2018 *
Osteoporosis to Prevent Fractures: Screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.	B	June 2018 *
Perinatal Depression: Preventive Interventions: pregnant and postpartum persons	The USPSTF recommends that clinicians provide or refer pregnant and postpartum persons who are at increased risk of perinatal depression to counseling interventions.	B	February 2019
Preeclampsia: Screening: pregnant woman	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	B	April 2017 *
Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis: persons at high risk of hiv acquisition	The USPSTF recommends that clinicians offer preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. See the Clinical Considerations section for information about identification of persons at high risk and selection of effective antiretroviral therapy.	A	June 2019

Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco	The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents.	B	April 2020 *
Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women	The USPSTF recommends repeated Rh(D) antibody testing for all unsensitized Rh(D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D)-negative.	B	February 2004 *
Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit	The USPSTF strongly recommends Rh(D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004 *
Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk	The USPSTF recommends behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs). See the Practice Considerations section for more information on populations at increased risk for acquiring STIs.	B	August 2020 *
Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	B	March 2018 *
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of cvd, 1 or more cvd risk factors, and a calculated 10-year cvd event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (ie, symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 40 to 75 years. See the "Clinical Considerations" section for more information on lipids screening and the assessment of cardiovascular risk.	B	November 2016 *

Syphilis Infection in Nonpregnant Adults and Adolescents: Screening : asymptomatic, nonpregnant adults and adolescents who are at increased risk for syphilis infection	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	June 2016 *
Syphilis Infection in Pregnant Women: Screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.	A	September 2018 *
Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration (FDA)-- approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.	A	January 2021 *
Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons: pregnant persons	The USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco.	A	January 2021 *
Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.	B	November 2018 *
Unhealthy Drug Use: Screening: adults age 18 years or older	The USPSTF recommends screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. (Screening refers to asking questions about unhealthy drug use, not testing biological specimens.)	B	June 2020
Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years	The USPSTF recommends vision screening at least once in all children aged 3 to 5 years to detect amblyopia or its risk factors.	B	September 2017 *

Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.	B	September 2018 *
--	---	---	------------------

Pages: 1

†The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to <http://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening1>.

\*Previous recommendation was an “A” or “B.”

# Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES  
**2021**

## Vaccines in the Child and Adolescent Immunization Schedule\*

Vaccines	Abbreviations	Trade names
Diphtheria, tetanus, and acellular pertussis vaccine	<b>DTaP</b>	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	<b>DT</b>	No trade name
<i>Haemophilus influenzae</i> type b vaccine	<b>Hib (PRP-T)</b> <b>Hib (PRP-OMP)</b>	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	<b>HepA</b>	Havrix® Vaqta®
Hepatitis B vaccine	<b>HepB</b>	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	<b>HPV</b>	Gardasil 9®
Influenza vaccine (inactivated)	<b>IIV</b>	Multiple
Influenza vaccine (live, attenuated)	<b>LAIV4</b>	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	<b>MMR</b>	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	<b>MenACWY-D</b> <b>MenACWY-CRM</b> <b>MenACWY-TT</b>	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	<b>MenB-4C</b> <b>MenB-FHbp</b>	Bexsero® Trumenba®
Pneumococcal 13-valent conjugate vaccine	<b>PCV13</b>	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	<b>PPSV23</b>	Pneumovax 23®
Poliovirus vaccine (inactivated)	<b>IPV</b>	IPOL®
Rotavirus vaccine	<b>RV1</b> <b>RV5</b>	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	<b>Tdap</b>	Adacel® Boostrix®
Tetanus and diphtheria vaccine	<b>Td</b>	Tenivac® Tdvax™
Varicella vaccine	<b>VAR</b>	Varivax®
<b>Combination vaccines (use combination vaccines instead of separate injections when appropriate)</b>		
DTaP, hepatitis B, and inactivated poliovirus vaccine	<b>DTaP-HepB-IPV</b>	Pediarix®
DTaP, inactivated poliovirus, and <i>Haemophilus influenzae</i> type b vaccine	<b>DTaP-IPV/Hib</b>	Pentacel®
DTaP and inactivated poliovirus vaccine	<b>DTaP-IPV</b>	Kinrix® Quadracel®
DTaP, inactivated poliovirus, <i>Haemophilus influenzae</i> type b, and hepatitis B vaccine	<b>DTaP-IPV-Hib-HepB</b>	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	<b>MMRV</b>	ProQuad®

\*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

## How to use the child/adolescent immunization schedule

- 1** Determine recommended vaccine by age (**Table 1**)
- 2** Determine recommended interval for catch-up vaccination (**Table 2**)
- 3** Assess need for additional recommended vaccines by medical condition and other indications (**Table 3**)
- 4** Review vaccine types, frequencies, intervals, and considerations for special situations (**Notes**)

Recommended by the Advisory Committee on Immunization Practices ([www.cdc.gov/vaccines/acip](http://www.cdc.gov/vaccines/acip)) and approved by the Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)), American Academy of Pediatrics ([www.aap.org](http://www.aap.org)), American Academy of Family Physicians ([www.aafp.org](http://www.aafp.org)), American College of Obstetricians and Gynecologists ([www.acog.org](http://www.acog.org)), American College of Nurse-Midwives ([www.midwife.org](http://www.midwife.org)), American Academy of Physician Assistants ([www.aapa.org](http://www.aapa.org)), and National Association of Pediatric Nurse Practitioners ([www.napnap.org](http://www.napnap.org)).

## Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or 800-822-7967



Download the CDC Vaccine Schedules App for providers at [www.cdc.gov/vaccines/schedules/hcp/schedule-app.html](http://www.cdc.gov/vaccines/schedules/hcp/schedule-app.html).

## Helpful information

- Complete ACIP recommendations: [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)
- *General Best Practice Guidelines for Immunization*: [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html)
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases: [www.cdc.gov/vaccines/pubs/surv-manual](http://www.cdc.gov/vaccines/pubs/surv-manual)
- ACIP Shared Clinical Decision-Making Recommendations [www.cdc.gov/vaccines/acip/acip-scdm-faqs.html](http://www.cdc.gov/vaccines/acip/acip-scdm-faqs.html)



**U.S. Department of Health and Human Services**  
Centers for Disease Control and Prevention

# Table 1

## Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

**These recommendations must be read with the notes that follow.** For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Hepatitis B (HepB)	1 <sup>st</sup> dose	←--- 2 <sup>nd</sup> dose ---→			←----- 3 <sup>rd</sup> dose -----→												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose				←--- 4 <sup>th</sup> dose ---→			5 <sup>th</sup> dose					
Haemophilus influenzae type b (Hib)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	See Notes		← 3 <sup>rd</sup> or 4 <sup>th</sup> dose, See Notes →										
Pneumococcal conjugate (PCV13)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	3 <sup>rd</sup> dose		←--- 4 <sup>th</sup> dose ---→										
Inactivated poliovirus (IPV <18 yrs)			1 <sup>st</sup> dose	2 <sup>nd</sup> dose	←----- 3 <sup>rd</sup> dose -----→						4 <sup>th</sup> dose						
Influenza (IIV)					Annual vaccination 1 or 2 doses								Annual vaccination 1 dose only				
<b>or</b>														<b>or</b>			
Influenza (LAIV4)														Annual vaccination 1 or 2 doses	Annual vaccination 1 dose only		
Measles, mumps, rubella (MMR)					See Notes	←--- 1 <sup>st</sup> dose ---→						2 <sup>nd</sup> dose					
Varicella (VAR)						←--- 1 <sup>st</sup> dose ---→						2 <sup>nd</sup> dose					
Hepatitis A (HepA)					See Notes	2-dose series, See Notes											
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)																	Tdap
Human papillomavirus (HPV)														*	See Notes		
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes											1 <sup>st</sup> dose		2 <sup>nd</sup> dose	
Meningococcal B															See Notes		
Pneumococcal polysaccharide (PPSV23)															See Notes		

  Range of recommended ages for all children
   Range of recommended ages for catch-up immunization
   Range of recommended ages for certain high-risk groups
   Recommended based on shared clinical decision-making or \*can be used in this age group
   No recommendation/not applicable



# Table 2

## Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 month Behind, United States, 2021

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the notes that follow.**

Children age 4 months through 6 years					
Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Hepatitis B	Birth	<b>4 weeks</b>	<b>8 weeks and at least 16 weeks after first dose.</b> Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	<b>4 weeks</b>	<b>4 weeks</b> Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	<b>4 weeks</b>	<b>4 weeks</b>	<b>6 months</b>	<b>6 months</b>
<i>Haemophilus influenzae</i> type b	6 weeks	<b>No further doses needed</b> if first dose was administered at age 15 months or older. <b>4 weeks</b> if first dose was administered before the 1 <sup>st</sup> birthday. <b>8 weeks (as final dose)</b> if first dose was administered at age 12 through 14 months.	<b>No further doses needed</b> if previous dose was administered at age 15 months or older. <b>4 weeks</b> if current age is younger than 12 months <b>and</b> first dose was administered at younger than age 7 months <b>and</b> at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. <b>8 weeks and age 12 through 59 months (as final dose)</b> if current age is younger than 12 months <b>and</b> first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months <b>and</b> first dose was administered before the 1 <sup>st</sup> birthday <b>and</b> second dose was administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB, Comvax) <b>and</b> were administered before the 1 <sup>st</sup> birthday.	<b>8 weeks (as final dose)</b> This dose only necessary for children age 12 through 59 months who received 3 doses before the 1 <sup>st</sup> birthday.	
Pneumococcal conjugate	6 weeks	<b>No further doses needed</b> for healthy children if first dose was administered at age 24 months or older. <b>4 weeks</b> if first dose was administered before the 1 <sup>st</sup> birthday. <b>8 weeks (as final dose for healthy children)</b> if first dose was administered at the 1 <sup>st</sup> birthday or after.	<b>No further doses needed</b> for healthy children if previous dose was administered at age 24 months or older. <b>4 weeks</b> if current age is younger than 12 months and previous dose was administered at <7 months old. <b>8 weeks (as final dose for healthy children)</b> if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months.	<b>8 weeks (as final dose)</b> This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	<b>4 weeks</b>	<b>4 weeks</b> if current age is <4 years. <b>6 months (as final dose)</b> if current age is 4 years or older.	<b>6 months</b> (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	<b>4 weeks</b>			
Varicella	12 months	<b>3 months</b>			
Hepatitis A	12 months	<b>6 months</b>			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D 2 years MenACWY-TT	<b>8 weeks</b>	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	<b>8 weeks</b>			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	<b>4 weeks</b>	<b>4 weeks</b> if first dose of DTaP/DT was administered before the 1 <sup>st</sup> birthday. <b>6 months (as final dose)</b> if first dose of DTaP/DT or Tdap/Td was administered at or after the 1 <sup>st</sup> birthday.	<b>6 months</b> if first dose of DTaP/DT was administered before the 1 <sup>st</sup> birthday.	
Human papillomavirus	9 years	<b>Routine dosing intervals are recommended.</b>			
Hepatitis A	N/A	<b>6 months</b>			
Hepatitis B	N/A	<b>4 weeks</b>	<b>8 weeks and at least 16 weeks after first dose.</b>		
Inactivated poliovirus	N/A	<b>4 weeks</b>	<b>6 months</b> A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	<b>4 weeks</b>			
Varicella	N/A	<b>3 months</b> if younger than age 13 years. <b>4 weeks</b> if age 13 years or older.			

**Table 3**

**Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2021**

Always use this table in conjunction with Table 1 and the notes that follow.

VACCINE	INDICATION									
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count <sup>1</sup>		Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leak or cochlear implant	Asplenia or persistent complement deficiencies	Chronic liver disease	Diabetes
			<15% and total CD4 cell count of <200/mm <sup>3</sup>	≥15% and total CD4 cell count of ≥200/mm <sup>3</sup>						
Hepatitis B	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Rotavirus	Grey	Orange (SCID <sup>2</sup> )	Orange	Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Diphtheria, tetanus, and acellular pertussis (DTaP)	Grey	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
<i>Haemophilus influenzae</i> type b	Grey	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots
Pneumococcal conjugate	Grey	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots
Inactivated poliovirus	Orange	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Influenza (IIV)	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Influenza (LAIV4)	Red	Red	Red	Red	Orange (Asthma, wheezing: 2–4yrs <sup>3</sup> )	Red	Red	Red	Orange	Orange
Measles, mumps, rubella	Red (*)	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Varicella	Red (*)	Red	Red	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Hepatitis A	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Tetanus, diphtheria, and acellular pertussis (Tdap)	Yellow with dots	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Human papillomavirus	Red (*)	Yellow with dots	Yellow with dots	Yellow with dots	Yellow	Yellow	Yellow	Yellow	Yellow	Yellow
Meningococcal ACWY	Yellow	Yellow	Yellow with dots	Yellow with dots	Yellow	Yellow	Yellow	Yellow with dots	Yellow	Yellow
Meningococcal B	Orange	Purple	Purple	Purple	Purple	Purple	Purple	Yellow with dots	Purple	Purple
Pneumococcal polysaccharide	Purple	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots	Yellow with dots

Yellow Vaccination according to the routine schedule recommended
 Purple Recommended for persons with an additional risk factor for which the vaccine would be indicated
 Yellow with dots Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.
 Red Not recommended/contraindicated—vaccine should not be administered.
 Orange Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction
 Grey No recommendation/not applicable

\*Vaccinate after pregnancy.

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the *General Best Practice Guidelines for Immunization*, "Altered Immunocompetence," at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html) and Table 4-1 (footnote D) at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html).

2 Severe Combined Immunodeficiency

3 LAIV4 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2021.

### Additional information

#### COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at [www.cdc.gov/vaccines/hcp/acip-recs/](http://www.cdc.gov/vaccines/hcp/acip-recs/).

- Consult relevant ACIP statements for detailed recommendations at [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- For information on contraindications and precautions for the use of a vaccine, consult the *General Best Practice Guidelines for Immunization* at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html) and relevant ACIP statements at [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of  $\geq 4$  months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as “through.”
- Vaccine doses administered  $\leq 4$  days before the minimum age or interval are considered valid. Doses of any vaccine administered  $\geq 5$  days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html).
- Information on travel vaccination requirements and recommendations is available at [www.cdc.gov/travel/](http://www.cdc.gov/travel/).
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html), and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31<sup>st</sup> ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see [www.hrsa.gov/vaccinecompensation/index.html](http://www.hrsa.gov/vaccinecompensation/index.html).

### Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadacel])

#### Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4<sup>th</sup> dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

#### Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

#### Special situations

- Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see [www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm](http://www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm).

### Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

#### Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

#### Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Do not require catch-up vaccination
- For other catch-up guidance, see Table 2.

### Special situations

#### • Chemotherapy or radiation treatment:

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.*

#### • Hematopoietic stem cell transplant (HSCT):

- 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history

#### • Anatomic or functional asplenia (including sickle cell disease):

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

##### Unvaccinated\* persons age 5 years or older

- 1 dose

#### • Elective splenectomy:

##### Unvaccinated\* persons age 15 months or older

- 1 dose (preferably at least 14 days before procedure)

#### • HIV infection:

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

##### Unvaccinated\* persons age 5–18 years

- 1 dose

#### • Immunoglobulin deficiency, early component complement deficiency:

##### 12–59 months

- Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
- 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

\*Unvaccinated = Less than routine series (through age 14 months) OR no doses (age 15 months or older)

**Hepatitis A vaccination**

(minimum age: 12 months for routine vaccination)

**Routine vaccination**

- 2-dose series (minimum interval: 6 months) beginning at age 12 months

**Catch-up vaccination**

- Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**<sup>®</sup>, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

**International travel**

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A ([www.cdc.gov/travel/](http://www.cdc.gov/travel/)):
  - **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between age 12–23 months.
  - **Unvaccinated age 12 months or older:** Administer dose 1 as soon as travel is considered.

**Hepatitis B vaccination**

(minimum age: birth)

**Birth dose (monovalent HepB vaccine only)**

- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for all medically stable infants  $\geq 2,000$  grams. Infants  $< 2,000$  grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still  $< 2,000$  grams).
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants  $< 2,000$  grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants  $< 2,000$  grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants  $\geq 2,000$  grams as soon as possible, but no later than 7 days of age.

**Routine series**

- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.

- **Minimum age** for the final (3<sup>rd</sup> or 4<sup>th</sup>) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute “dose 4” for “dose 3” in these calculations)

**Catch-up vaccination**

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years or older may receive a 2-dose series of HepB (**Heplisav-B**<sup>®</sup>) at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).
- For other catch-up guidance, see Table 2.

**Special situations**

- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Revaccination** may be recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**
- For detailed revaccination recommendations, see [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html).

**Human papillomavirus vaccination**

(minimum age: 9 years)

**Routine and catch-up vaccination**

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination:** 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine.

**Special situations**

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

**Influenza vaccination**

(minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

**Routine vaccination**

- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2020, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2020
  - 1 dose for **all persons age 9 years or older**
- For the 2021–22 season, see the 2021–22 ACIP influenza vaccine recommendations.

**Special situations**

- **Egg allergy, hives only:** Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress, need for emergency medical services or epinephrine): Any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than Flublok or Flucelvax, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to vaccines can occur even in the absence of a history of previous allergic reaction. All vaccination providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of any influenza vaccine.
- **LAIV4 should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg, see details above)
  - Receiving aspirin or salicylate-containing medications
  - Age 2–4 years with history of asthma or wheezing
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cochlear implant
  - Cerebrospinal fluid-oro-pharyngeal communication
  - Children less than age 2 years
  - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days

## Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

### Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

### Catch-up vaccination

- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.

### Special situations

#### International travel

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months or older:** 2-dose series at least 4 weeks apart before departure

## Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra], 2 years [MenACWY-TT, MenQuadfi])

### Routine vaccination

- 2-dose series at 11–12 years, 16 years

### Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

### Special situations

**Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:**

- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

#### • MenQuadfi

- Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

**Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj ([www.cdc.gov/travel/](http://www.cdc.gov/travel/)):**

- Children less than age 24 months:
  - **Menveo (age 2–23 months)**
    - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra (age 9–23 months)**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose Menveo, Menactra, or MenQuadfi

**First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:**

- 1 dose **Menveo, Menactra, or MenQuadfi**
- Adolescent vaccination of children who received MenACWY prior to age 10 years:**
- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
  - **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

**Note:** **Menactra** should be administered either before or at the same time as DTaP. For MenACWY **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm).

## Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

### Shared clinical decision-making

- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3<sup>rd</sup> dose at least 4 months after dose 2.

### Special situations

**Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:**

- **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 3-dose series at 0, 1–2, 6 months
- Bexsero** and **Trumenba** are not interchangeable; the same product should be used for all doses in a series. For MenB **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm).

### Pneumococcal vaccination

(minimum age: 6 weeks [PCV13], 2 years [PPSV23])

### Routine vaccination with PCV13

- 4-dose series at 2, 4, 6, 12–15 months

### Catch-up vaccination with PCV13

- 1 dose for healthy children age 24–59 months with any incomplete\* PCV13 series
- For other catch-up guidance, see Table 2.

### Special situations

**Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.**

**Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:**

#### Age 2–5 years

- Any incomplete\* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

#### Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

**Cerebrospinal fluid leak, cochlear implant:**

#### Age 2–5 years

- Any incomplete\* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

#### Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

**Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:**

#### Age 2–5 years

- Any incomplete\* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2<sup>nd</sup> dose of PPSV23 5 years later

#### Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2<sup>nd</sup> dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

#### Chronic liver disease, alcoholism:

##### Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

\**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations ([www.cdc.gov/mmwr/pdf/rr/rr5911.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf)) for complete schedule details.

### Poliovirus vaccination (minimum age: 6 weeks)

#### Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

#### Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents age 18 years or older.

**Series containing oral polio vaccine (OPV)**, either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See [www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s\\_cid=mm6601a6\\_w](http://www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w).
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as “OPV,” see [www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s\\_cid=mm6606a7\\_w](http://www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w).
- For other catch-up guidance, see Table 2.

### Rotavirus vaccination (minimum age: 6 weeks)

#### Routine vaccination

- **Rotarix:** 2-dose series at 2 and 4 months
- **RotaTeq:** 3-dose series at 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

#### Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

### Tetanus, diphtheria, and pertussis (Tdap) vaccination

(minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

#### Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

#### Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated\* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - **Children age 10 years** who receive Tdap do not need the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years:**
  - **Children age 7–9 years:** DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

#### Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see [www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm](http://www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm).

\**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

### Varicella vaccination (minimum age: 12 months)

#### Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

#### Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at [www.cdc.gov/mmwr/pdf/rr/rr5604.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf)) have a 2-dose series:
  - **Age 7–12 years:** routine interval: 3 months (a dose administered after a 4-week interval may be counted)
  - **Age 13 years and older:** routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.

# Recommended Adult Immunization Schedule for ages 19 years or older

UNITED STATES  
**2021**

## How to use the adult immunization schedule

- 1** Determine recommended vaccinations by age (**Table 1**)
- 2** Assess need for additional recommended vaccinations by medical condition and other indications (**Table 2**)
- 3** Review vaccine types, frequencies, and intervals and considerations for special situations (**Notes**)

Recommended by the Advisory Committee on Immunization Practices ([www.cdc.gov/vaccines/acip](http://www.cdc.gov/vaccines/acip)) and approved by the Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)), American College of Physicians ([www.acponline.org](http://www.acponline.org)), American Academy of Family Physicians ([www.aafp.org](http://www.aafp.org)), American College of Obstetricians and Gynecologists ([www.acog.org](http://www.acog.org)), American College of Nurse-Midwives ([www.midwife.org](http://www.midwife.org)), and American Academy of Physician Assistants ([www.aapa.org](http://www.aapa.org)).

## Vaccines in the Adult Immunization Schedule\*

Vaccines	Abbreviations	Trade names
<i>Haemophilus influenzae</i> type b vaccine	Hib	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis A and hepatitis B vaccine	HepA-HepB	Twinrix®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB® Hepelisav-B®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV	Many brands
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Influenza vaccine (recombinant)	RIV4	Flublok® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax 23®
Tetanus and diphtheria toxoids	Td	Tenivac® Tdvax™
Tetanus and diphtheria toxoids and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Varicella vaccine	VAR	Varivax®
Zoster vaccine, recombinant	RZV	Shingrix

\*Administer recommended vaccines if vaccination history is incomplete or unknown. Do not restart or add doses to vaccine series if there are extended intervals between doses. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

## Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to the local or state health department
- Clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System at [www.vaers.hhs.gov](http://www.vaers.hhs.gov) or 800-822-7967

## Injury claims

All vaccines included in the adult immunization schedule except pneumococcal 23-valent polysaccharide (PPSV23) and zoster (RZV) vaccines are covered by the Vaccine Injury Compensation Program. Information on how to file a vaccine injury claim is available at [www.hrsa.gov/vaccinecompensation](http://www.hrsa.gov/vaccinecompensation).

## Questions or comments

Contact [www.cdc.gov/cdc-info](http://www.cdc.gov/cdc-info) or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays.



Download the CDC Vaccine Schedules app for providers at [www.cdc.gov/vaccines/schedules/hcp/schedule-app.html](http://www.cdc.gov/vaccines/schedules/hcp/schedule-app.html).

## Helpful information

- Complete ACIP recommendations: [www.cdc.gov/vaccines/hcp/acip-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/index.html)
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): [www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html](http://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html)
- Vaccine information statements: [www.cdc.gov/vaccines/hcp/vis/index.html](http://www.cdc.gov/vaccines/hcp/vis/index.html)
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): [www.cdc.gov/vaccines/pubs/surv-manual](http://www.cdc.gov/vaccines/pubs/surv-manual)
- Travel vaccine recommendations: [www.cdc.gov/travel](http://www.cdc.gov/travel)
- Recommended Child and Adolescent Immunization Schedule, United States, 2021: [www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html](http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html)
- ACIP Shared Clinical Decision-Making Recommendations [www.cdc.gov/vaccines/acip/acip-scdm-faqs.html](http://www.cdc.gov/vaccines/acip/acip-scdm-faqs.html)



**U.S. Department of  
Health and Human Services**  
Centers for Disease  
Control and Prevention

**Table 1** Recommended Adult Immunization Schedule by Age Group, United States, 2021

Vaccine	19–26 years	27–49 years	50–64 years	≥65 years
<b>Influenza inactivated (IIV) or Influenza recombinant (RIV4)</b> <i>or</i>	1 dose annually			
<b>Influenza live, attenuated (LAIV4)</b>				
<b>Tetanus, diphtheria, pertussis (Tdap or Td)</b>	1 dose Tdap each pregnancy; 1 dose Td/Tdap for wound management (see notes)			
	1 dose Tdap, then Td or Tdap booster every 10 years			
<b>Measles, mumps, rubella (MMR)</b>	1 or 2 doses depending on indication (if born in 1957 or later)			
<b>Varicella (VAR)</b>	2 doses (if born in 1980 or later)		2 doses	
<b>Zoster recombinant (RZV)</b>			2 doses	
<b>Human papillomavirus (HPV)</b>	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
<b>Pneumococcal conjugate (PCV13)</b>	1 dose			1 dose
<b>Pneumococcal polysaccharide (PPSV23)</b>	1 or 2 doses depending on indication			1 dose
<b>Hepatitis A (HepA)</b>	2 or 3 doses depending on vaccine			
<b>Hepatitis B (HepB)</b>	2 or 3 doses depending on vaccine			
<b>Meningococcal A, C, W, Y (MenACWY)</b>	1 or 2 doses depending on indication, see notes for booster recommendations			
<b>Meningococcal B (MenB)</b>	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations			
	19 through 23 years			
<b>Haemophilus influenzae type b (Hib)</b>	1 or 3 doses depending on indication			

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or other indication

Recommended vaccination based on shared clinical decision-making

No recommendation/ Not applicable



**Table 2** Recommended Adult Immunization Schedule by Medical Condition and Other Indications, United States, 2021

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count		Asplenia, complement deficiencies	End-stage renal disease; or on hemodialysis	Heart or lung disease, alcoholism <sup>1</sup>	Chronic liver disease	Diabetes	Health care personnel <sup>2</sup>	Men who have sex with men
			<200 mm <sup>3</sup>	≥200 mm <sup>3</sup>							
IIV or RIV4 <b>or</b>	1 dose annually										
LAIV4	Not Recommended					Precaution			1 dose annually <b>or</b>		
Tdap or Td	1 dose Tdap each pregnancy	1 dose Tdap, then Td or Tdap booster every 10 years									
MMR	Not Recommended*	Not Recommended	1 or 2 doses depending on indication								
VAR	Not Recommended*	Not Recommended		2 doses							
RZV				2 doses at age ≥50 years							
HPV	Not Recommended*	3 doses through age 26 years		2 or 3 doses through age 26 years depending on age at initial vaccination or condition							
PCV13		1 dose									
PPSV23		1, 2, or 3 doses depending on age and indication									
HepA				2 or 3 doses depending on vaccine							
HepB				2, 3, or 4 doses depending on vaccine or condition				<60 years			
								≥60 years			
MenACWY	1 or 2 doses depending on indication, see notes for booster recommendations										
MenB	Precaution	2 or 3 doses depending on vaccine and indication, see notes for booster recommendations									
Hib		3 doses HSCT <sup>3</sup> recipients only		1 dose							

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection
 
 Recommended vaccination for adults with an additional risk factor or another indication
 

 Precaution—vaccination might be indicated if benefit of protection outweighs risk of adverse reaction
 

 Recommended vaccination based on shared clinical decision-making
 

 Not recommended/contraindicated—vaccine should not be administered.
 

 No recommendation/Not applicable

\*Vaccinate after pregnancy.

1. Precaution for LAIV4 does not apply to alcoholism. 2. See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. 3. Hematopoietic stem cell transplant.

For vaccine recommendations for persons 18 years of age or younger, see the Recommended Child/Adolescent Immunization Schedule.

### Additional Information

#### COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at [www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html](http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html)

### Haemophilus influenzae type b vaccination

#### Special situations

- **Anatomical or functional asplenia (including sickle cell disease):** 1 dose if previously did not receive Hib; if elective splenectomy, 1 dose, preferably at least 14 days before splenectomy
- **Hematopoietic stem cell transplant (HSCT):** 3-dose series 4 weeks apart starting 6–12 months after successful transplant, regardless of Hib vaccination history

### Hepatitis A vaccination

#### Routine vaccination

- **Not at risk but want protection from hepatitis A** (identification of risk factor not required): 2-dose series HepA (Havrix 6–12 months apart or Vaqta 6–18 months apart [minimum interval: 6 months]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

#### Special situations

- **At risk for hepatitis A virus infection:** 2-dose series HepA or 3-dose series HepA-HepB as above
  - **Chronic liver disease** (e.g., persons with hepatitis B, hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice the upper limit of normal)
  - **HIV infection**
  - **Men who have sex with men**
  - **Injection or noninjection drug use**

- **Persons experiencing homelessness**
- **Work with hepatitis A virus** in research laboratory or with nonhuman primates with hepatitis A virus infection
- **Travel in countries with high or intermediate endemic hepatitis A** (HepA-HepB [Twinrix] may be administered on an accelerated schedule of 3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months)
- **Close, personal contact with international adoptee** (e.g., household or regular babysitting) in first 60 days after arrival from country with high or intermediate endemic hepatitis A (administer dose 1 as soon as adoption is planned, at least 2 weeks before adoptee's arrival)
- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy
- **Settings for exposure, including** health care settings targeting services to injection or noninjection drug users or group homes and nonresidential day care facilities for developmentally disabled persons (individual risk factor screening not required)

### Hepatitis B vaccination

#### Routine vaccination

- **Not at risk but want protection from hepatitis B** (identification of risk factor not required): 2- or 3-dose series (2-dose series Heplisav-B at least 4 weeks apart [2-dose series HepB only applies when 2 doses of Heplisav-B are used at least 4 weeks apart] or 3-dose series Engerix-B or Recombivax HB at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks]) or 3-dose series HepA-HepB (Twinrix at 0, 1, 6 months [minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 5 months])

#### Special situations

- **At risk for hepatitis B virus infection:** 2-dose (Heplisav-B) or 3-dose (Engerix-B, Recombivax HB) series or 3-dose series HepA-HepB (Twinrix) as above
  - **Chronic liver disease** (e.g., persons with hepatitis C, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, alanine aminotransferase [ALT] or aspartate aminotransferase [AST] level greater than twice upper limit of normal)
  - **HIV infection**
  - **Sexual exposure risk** (e.g., sex partners of hepatitis B surface antigen [HBsAg]-positive persons; sexually active persons not in mutually monogamous relationships; persons seeking partner for a sexually transmitted infection; men who have sex with men)

- **Current or recent injection drug use**
- **Percutaneous or mucosal risk for exposure to blood** (e.g., household contacts of HBsAg-positive persons; residents and staff of facilities for developmentally disabled persons; health care and public safety personnel with reasonably anticipated risk for exposure to blood or blood-contaminated body fluids; hemodialysis, peritoneal dialysis, home dialysis, and predialysis patients; persons with diabetes mellitus age younger than 60 years, shared clinical decision-making for persons age 60 years or older)
- **Incarcerated persons**
- **Travel in countries with high or intermediate endemic hepatitis B**
- **Pregnancy** if at risk for infection or severe outcome from infection during pregnancy (Heplisav-B not currently recommended due to lack of safety data in pregnant women)

### Human papillomavirus vaccination

#### Routine vaccination

- **HPV vaccination recommended for all persons through age 26 years:** 2- or 3-dose series depending on age at initial vaccination or condition:
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
  - **Age 9–14 years at initial vaccination and received 1 dose or 2 doses less than 5 months apart:** 1 additional dose
  - **Age 9–14 years at initial vaccination and received 2 doses at least 5 months apart:** HPV vaccination series complete, no additional dose needed
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted
- **No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine**

#### Shared clinical decision-making

- **Some adults age 27–45 years:** Based on shared clinical decision-making, 2- or 3-dose series as above

#### Special situations

- **Age ranges recommended above for routine and catch-up vaccination or shared clinical decision-making also apply in special situations**

# Notes

## Recommended Adult Immunization Schedule, United States, 2021

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above, regardless of age at initial vaccination
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

### Influenza vaccination

#### Routine vaccination

- **Persons age 6 months or older:** 1 dose any influenza vaccine appropriate for age and health status annually
- For additional guidance, see [www.cdc.gov/flu/professionals/index.htm](http://www.cdc.gov/flu/professionals/index.htm)

#### Special situations

- **Egg allergy, hives only:** 1 dose any influenza vaccine appropriate for age and health status annually
- **Egg allergy—any symptom other than hives** (e.g., angioedema, respiratory distress): 1 dose any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than RIV4 or cLIV4, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to any vaccine can occur even in the absence of a history of previous allergic reaction. Therefore, all vaccine providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to any influenza vaccine is a contraindication to future receipt of the vaccine.
- **LAIV4 should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to any vaccine component (excluding egg) or to a previous dose of any influenza vaccine
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cranial CSF/oropharyngeal communications
  - Cochlear implant

- Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days
- Adults 50 years or older
- **History of Guillain-Barré syndrome within 6 weeks after previous dose of influenza vaccine:** Generally, should not be vaccinated unless vaccination benefits outweigh risks for those at higher risk for severe complications from influenza

### Measles, mumps, and rubella vaccination

#### Routine vaccination

- **No evidence of immunity to measles, mumps, or rubella:** 1 dose
  - **Evidence of immunity:** Born before 1957 (health care personnel, see below), documentation of receipt of MMR vaccine, laboratory evidence of immunity or disease (diagnosis of disease without laboratory confirmation is not evidence of immunity)

#### Special situations

- **Pregnancy with no evidence of immunity to rubella:** MMR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose
- **Nonpregnant women of childbearing age with no evidence of immunity to rubella:** 1 dose
- **HIV infection with CD4 count  $\geq 200$  cells/mm<sup>3</sup> for at least 6 months and no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart; MMR contraindicated for HIV infection with CD4 count  $< 200$  cells/mm<sup>3</sup>
- **Severe immunocompromising conditions:** MMR contraindicated
- **Students in postsecondary educational institutions, international travelers, and household or close, personal contacts of immunocompromised persons with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart if previously did not receive any doses of MMR or 1 dose if previously received 1 dose MMR
- **Health care personnel:**
  - **Born in 1957 or later with no evidence of immunity to measles, mumps, or rubella:** 2-dose series at least 4 weeks apart for measles or mumps or at least 1 dose for rubella

- **Born before 1957 with no evidence of immunity to measles, mumps, or rubella:** Consider 2-dose series at least 4 weeks apart for measles or mumps or 1 dose for rubella

### Meningococcal vaccination

#### Special situations for MenACWY

- **Anatomical or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:** 2-dose series MenACWY-D (Menactra, Menveo or MenQuadfi) at least 8 weeks apart and revaccinate every 5 years if risk remains
- **Travel in countries with hyperendemic or epidemic meningococcal disease, microbiologists routinely exposed to *Neisseria meningitidis*:** 1 dose MenACWY (Menactra, Menveo or MenQuadfi) and revaccinate every 5 years if risk remains
- **First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) and military recruits:** 1 dose MenACWY (Menactra, Menveo or MenQuadfi)
- For MenACWY **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm)

#### Shared clinical decision-making for MenB

- **Adolescents and young adults age 16–23 years (age 16–18 years preferred) not at increased risk for meningococcal disease:** Based on shared clinical decision-making, 2-dose series MenB-4C (Bexsero) at least 1 month apart or 2-dose series MenB-FHbp (Trumenba) at 0, 6 months (if dose 2 was administered less than 6 months after dose 1, administer dose 3 at least 4 months after dose 2); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series)

#### Special situations for MenB

- **Anatomical or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use, microbiologists routinely exposed to *Neisseria meningitidis*:** 2-dose primary series MenB-4C (Bexsero) at least one month apart or

- MenB-4C (Bexsero) at least 1 month apart or 3-dose primary series MenB-FHbp (Trumenba) at 0, 1–2, 6 months (if dose 2 was administered at least 6 months after dose 1, dose 3 not needed); MenB-4C and MenB-FHbp are not interchangeable (use same product for all doses in series); 1 dose MenB booster 1 year after primary series and revaccinate every 2–3 years if risk remains
- **Pregnancy:** Delay MenB until after pregnancy unless at increased risk and vaccination benefits outweigh potential risks
- For MenB **booster dose recommendations** for groups listed under “Special situations” and in an outbreak setting (e.g., in community or organizational settings and among men who have sex with men) and additional meningococcal vaccination information, see [www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm](http://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm)

## Pneumococcal vaccination

### Routine vaccination

- **Age 65 years or older** (immunocompetent—see [www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s\\_cid=mm6846a5\\_w](http://www.cdc.gov/mmwr/volumes/68/wr/mm6846a5.htm?s_cid=mm6846a5_w)): 1 dose PPSV23
  - If PPSV23 was administered prior to age 65 years, administer 1 dose PPSV23 at least 5 years after previous dose

### Shared clinical decision-making

- **Age 65 years or older** (immunocompetent): 1 dose PCV13 based on **shared clinical decision-making** if previously not administered.
  - PCV13 and PPSV23 should not be administered during the same visit
  - If both PCV13 and PPSV23 are to be administered, PCV13 should be administered first
  - PCV13 and PPSV23 should be administered at least 1 year apart

### Special situations

- **Age 19–64 years with chronic medical conditions (chronic heart [excluding hypertension], lung, or liver disease, diabetes), alcoholism, or cigarette smoking:** 1 dose PPSV23

- **Age 19 years or older with immunocompromising conditions (congenital or acquired immunodeficiency [including B- and T-lymphocyte deficiency, complement deficiencies, phagocytic disorders, HIV infection], chronic renal failure, nephrotic syndrome, leukemia, lymphoma, Hodgkin disease, generalized malignancy, iatrogenic immunosuppression [e.g., drug or radiation therapy], solid organ transplant, multiple myeloma) or anatomical or functional asplenia (including sickle cell disease and other hemoglobinopathies):** 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later, then another dose PPSV23 at least 5 years after previous PPSV23; at age 65 years or older, administer 1 dose PPSV23 at least 5 years after most recent PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)
- **Age 19 years or older with cerebrospinal fluid leak or cochlear implant:** 1 dose PCV13 followed by 1 dose PPSV23 at least 8 weeks later; at age 65 years or older, administer another dose PPSV23 at least 5 years after PPSV23 (note: only 1 dose PPSV23 recommended at age 65 years or older)

## Tetanus, diphtheria, and pertussis vaccination

### Routine vaccination

- **Previously did not receive Tdap at or after age 11 years:** 1 dose Tdap, then Td or Tdap every 10 years

### Special situations

- **Previously did not receive primary vaccination series for tetanus, diphtheria, or pertussis:** At least 1 dose Tdap followed by 1 dose Td or Tdap at least 4 weeks after Tdap and another dose Td or Tdap 6–12 months after last Td or Tdap (Tdap can be substituted for any Td dose, but preferred as first dose), Td or Tdap every 10 years thereafter
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- **Wound management:** Persons with 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant woman, use Tdap. For detailed information, see [www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm](http://www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm)

## Varicella vaccination

### Routine vaccination

- **No evidence of immunity to varicella:** 2-dose series 4–8 weeks apart if previously did not receive varicella-containing vaccine (VAR or MMRV [measles-mumps-rubella-varicella vaccine] for children); if previously received 1 dose varicella-containing vaccine, 1 dose at least 4 weeks after first dose
  - Evidence of immunity: U.S.-born before 1980 (except for pregnant women and health care personnel [see below]), documentation of 2 doses varicella-containing vaccine at least 4 weeks apart, diagnosis or verification of history of varicella or herpes zoster by a health care provider, laboratory evidence of immunity or disease

### Special situations

- **Pregnancy with no evidence of immunity to varicella:** VAR contraindicated during pregnancy; after pregnancy (before discharge from health care facility), 1 dose if previously received 1 dose varicella-containing vaccine or dose 1 of 2-dose series (dose 2: 4–8 weeks later) if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **Health care personnel with no evidence of immunity to varicella:** 1 dose if previously received 1 dose varicella-containing vaccine; 2-dose series 4–8 weeks apart if previously did not receive any varicella-containing vaccine, regardless of whether U.S.-born before 1980
- **HIV infection with CD4 count  $\geq 200$  cells/mm<sup>3</sup> with no evidence of immunity:** Vaccination may be considered (2 doses 3 months apart); VAR contraindicated for HIV infection with CD4 count  $< 200$  cells/mm<sup>3</sup>
- **Severe immunocompromising conditions:** VAR contraindicated

## Zoster vaccination

### Routine vaccination

- **Age 50 years or older:** 2-dose series RZV (Shingrix) 2–6 months apart (minimum interval: 4 weeks; repeat dose if administered too soon), regardless of previous herpes zoster or history of zoster vaccine live (ZVL, Zostavax) vaccination (administer RZV at least 2 months after ZVL)

### Special situations

- **Pregnancy:** Consider delaying RZV until after pregnancy if RZV is otherwise indicated.
- **Severe immunocompromising conditions (including HIV infection with CD4 count  $< 200$  cells/mm<sup>3</sup>):** Recommended use of RZV under review

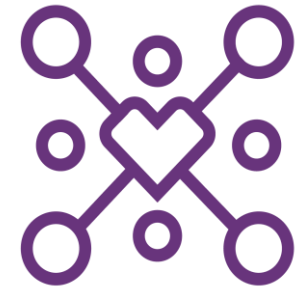
# Preventive Care

Lydia Bartholomew, MD MHA FAACPE FAAFP CHIE  
Chief Medical Officer, Clinical Health Services West  
Senior Director, Clinical Solutions, NW and Mountain, Medical Health Services

# Overview

We will discuss the following issues:

- Developing clinical policies
- Affordable Care Act defined Preventive Care
- Evaluating & implementing changes to recommended Preventive Care services
- Review Aetna's Preventive Care Services



# Developing Clinical Policy Bulletins (CPBs)

- Designated teams of individuals review emerging evidence and recommendations
- Emerging evidence and recommendations are reviewed against established criteria
- Policies are reviewed at least once annually or on an ad hoc basis with emerging evidence and recommendations



# ACA defined Preventive Care

- Non-grandfathered plans are required to cover a set of preventive services at no cost to covered members.
- Services required based on recommendations from:
  - United States Preventive Services Task Force (USPSTF) services with an A or B grade
  - Standard vaccines recommended by Advisory Committee on Immunization Practices
  - Preventive care recommended for children by the Bright Futures guidelines

Source: <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/preventive-care-background>




# USPSTF Grades

Grade	Definition	Suggestions for Practice
<b>A</b>	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
<b>B</b>	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
<b>C</b>	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
<b>D</b>	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
<b>I Statement</b>	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Source: <https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes/grade-definitions>

# Aetna Preventive Care

- In general, Aetna follows ACA requirements to define a set of Preventive Care services that are covered at no cost to members of a non-grandfathered plan
- In some cases, Aetna may include a broader set of services or service definitions under its Preventive Care benefit at the recommendation of expert groups outside of those defined by the Affordable Care Act
- All of the services under Aetna's Preventive Care benefit are defined here: [LINK](#)




**Keep your health in check**

**Preventive care coverage at no extra cost**  
Get many checkups, screenings, vaccines, prenatal care services, contraceptives and more with no out-of-pocket costs.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies, including Aetna Life Insurance Company and its affiliates (Aetna).

Aetna.com  
10.03.2011 © 2020



# Evaluating new requirements

- As new USPSTF A&B rated services are, the clinical policy team convenes to review.
- Standard clinical review process convenes with input from Aetna's Legal & Compliance Departments.
- Decisions/changes approved by Aetna's Chief Medical Officer or designee.
- Members of the Clinical Policy Unit work with persons from coding and reimbursement areas (Medical Policy and Operations) regarding implementation of clinical polices in Aetna systems
- Additionally all policies on drugs and biologics covered under medical are also evaluated in the National Pharmacy and Therapeutics (P&T) process, so those treatments are evaluated by two separate groups and harmonized.

# Aetna policy: breast cancer screening

<p><b>USPSTF Grade(s)</b>  <b>*Update in Progress*</b></p>	<p><b>Mammogram</b>            C Grade – Women 40-49 years            B Grade – Women 50-74 Years every other year            I Grade – Women 75+</p> <p><b>Digital Breast Tomosynthesis/MRI/Ultrasonography, other</b>            I Grade – Women all ages &amp; Women with dense breasts</p>
<p><b>USPSTF Link</b></p>	<p><a href="#">LINK</a></p>
<p><b>Aetna Preventive</b></p>	<p>Women 40+            One per year</p>
<p><b>Aetna Medical</b></p>	<p>Medical necessity outlined in CPB.</p>
<p><b>Aetna CPB Link</b></p>	<p><a href="#">LINK</a></p>
<p><b>CPB Last &amp; Next Review</b></p>	<p>11/20/20, 06/24/21</p>
<p><b>Difference</b></p>	<p>Aetna covers annual mammogram as a preventive benefit for women aged 40+ regardless of indication.</p>

# Aetna policy: cervical cancer screening

<b>USPSTF Grade(s)</b>	<b>A Grade - Cervical Cytology</b> Women 21-65 Years every 3 years Women 30-65 Years every 5 years with high-risk HPV testing  <b>A Grade - High-risk human papillomavirus testing (hrHPV)</b> Women 30-65 Years every 5 years
<b>USPSTF Link</b>	<a href="#">LINK</a>
<b>Aetna Preventive</b>	<b>Cervical Cytology</b> Women 21+ once a year  <b>HPV</b> Women 30+ once a year
<b>Aetna Medical</b>	Medical necessity outlined in CPB.
<b>Aetna CPB Link</b>	<a href="#">LINK</a>
<b>CPB Last Review</b>	10/19/20
<b>CPB Next Review</b>	05/31/21
<b>Difference</b>	Aetna allows more frequent testing than officially recommended

# Aetna policy: prostate cancer screening

<b>USPSTF Grade(s)</b>	<b>Prostate-Specific Antigen (PSA)</b> C Grade – Men 55-69 Years D Grade – Men 70+ Years
<b>USPSTF Link</b>	<a href="#">LINK</a>
<b>Aetna Preventive</b>	<b>Prostate Specific Antigen (PSA)</b> Men 40+ once annually
<b>Aetna Medical</b>	Medical necessity outlined in CPB.
<b>Aetna CPB Link</b>	<a href="#">LINK</a>
<b>CPB Last Review</b>	11/25/20
<b>CPB Next Review</b>	06/10/21
<b>Difference</b>	Aetna covers as preventive under certain conditions whereas it is not a USPSTF Grade A or B service


# Aetna policy: colorectal cancer screening

<b>USPSTF Grade(s)</b>	B Grade – Adults aged 45-49 A Grade – Adults aged 50-70  Frequency depends on colorectal cancer screening type
<b>USPSTF Link</b>	<a href="#">LINK</a>
<b>Aetna Preventive</b>	Any Adult 45+  Frequency depends on colorectal cancer screening type
<b>Aetna Medical</b>	Medical Necessity outlined in CPB
<b>Aetna CPB Link</b>	<a href="#">LINK</a>
<b>CPB Last Review</b>	6/8/20
<b>CPB Next Review</b>	6/10/21
<b>Difference</b>	None

# Questions & Discussion





Executive Summary	<b>Specialty Medication Prior Authorizations (R020)</b>	
Health Plan Affected	Defined Benefit Retiree Plan	
Proposed Effective Date	January 1 <sup>st</sup> , 2022	
Reviewed By	Retiree Health Plan Advisory Board	
Review Date	September 9, 2021	

**1) Background**

The AlaskaCare Defined Benefit Retiree Health Plan (Plan) provides coverage for outpatient drugs for treatment of illness, disease, or injury if dispensed upon prescription of a provider acting within the scope of their license. Similar to Plan requirements for precertification for certain intensive, complex, or high-cost medical services, the Plan currently includes provisions that allow for a prior authorization review of certain medications to evaluate if the person utilizing the medication meets the medical necessity guidelines and clinical criteria established by the FDA and other evidence-based resources for safe and effective use.

Specialty medications are typically highly complex, high-cost, or high-touch drugs that often must be administered in a very specific manner. Many specialty medications are prescribed to treat chronic conditions, meaning that utilizers are likely to use that medication for a long time. In 2020, specialty costs for less than 1% of prescriptions (associated with 3.7% of utilizers) made up 37%, or \$110 million, of the total Plan prescription drug spend.

Currently the Plan does not have a prior authorization process in place for specialty medications. In a review of over 60 public health plans, the AlaskaCare retiree plan was the only plan without this process in place. As a result, the Plan’s Pharmacy Benefit Manager (OptumRx) does not have a means to receive and review the information necessary (e.g., basic diagnostic information) to ensure the patient meets the specific FDA and clinical criteria associated with appropriate and effective use of the specialty medication.

**2) Objectives**

- a) Promote safe and effective use of medications in accordance with evidence-based clinical standards.
- b) Employ prudent pharmacy management strategies to curtail unnecessary or unsafe medication utilization.

**3) Summary of Proposed Change**

Prior authorization requires prescribers to provide patient-specific medication treatment information for review prior to approval and dispensing to the patient. This review ensures that a prescription drug is appropriately prescribed, meets FDA and other clinical guidelines for the condition being treated, and is eligible for coverage.

The Division proposes implementing prior authorization requirements for specialty medications through OptumRx’s specialty prior authorization program. Prescribers would need to provide certain clinical data to OptumRx for a review prior to approval for coverage. In most cases these reviews are completed within 72 hours and prescribers can submit the request electronically. A list of specialty medications requiring prior authorization is available here: [OptumRx Specialty Pharmacy Drug List](#).

**4) Actuarial and Financial Impacts of Proposed Change**

This proposal will not result in a change to members’ cost share for their covered prescriptions, nor will it remove coverage for any drugs currently being covered by the plan. Therefore, implementing prior authorizations for specialty medications will not have an impact on the actuarial value of the Plan.

Savings accrue to the plan via increased drug manufacturer rebates associated with implementing prior authorizations, denials of medication due to inappropriate use of the drug, abandoned prior authorization requests, and alternative prescriptions being dispensed.

The anticipated financial impact to the plan associated with implementing prior authorizations is a reduction in costs of approximately \$7.7 million for 2022, and a potential \$100.8 million reduction in the healthcare Accrued Actuarial Liability associated with the plan.



Proposal Title	Specialty Medication Prior Authorizations (R020)
Health Plan Affected	Defined Benefit Retiree Plan
Proposed Effective Date	January 1 <sup>st</sup> , 2022
Reviewed By	Retiree Health Plan Advisory Board
Review Date	September 9, 2021

## Contents

1) BACKGROUND .....	2
2) OBJECTIVES .....	4
3) SUMMARY OF PROPOSED CHANGE .....	4
4) IMPACTS .....	7
Actuarial Impact   <b>Neutral</b> .....	7
Financial Impact   <b>Annual Cost Reduction ~\$7.7M</b> .....	7
Member Impact   <b>Low</b> .....	9
Operational Impact (DRB)   <b>Minimal</b> .....	10
Operational Impact (TPA)   <b>Minimal</b> .....	10
5) PROPOSAL RECOMMENDATIONS.....	10
<b>DRB Recommendation</b> .....	<b>10</b>
<b>RHPAB Board Recommendation</b> .....	<b>10</b>

# 1) Background

## *Specialty Medications*

Specialty medications are typically highly complex, high-cost, or high-touch drugs that often require very specialized storage protocols or must be administered in a very specific manner. Specialty drugs:<sup>1,2</sup>

- May be prescribed for a person with a complex or chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, and/or is debilitating or fatal if left untreated or under-treated;
- Treat rare or orphan disease<sup>3</sup> indications;
- Require additional patient education, adherence, and support beyond traditional dispensing activities;
- Are oral, injectable, inhalable, or infusible drugs;
- Have a high monthly cost (e.g., more than \$1,000 for a 30-day supply)<sup>4,5</sup>
- Have unique storage or shipment requirements, such as refrigeration; and
- Are not typically stocked at retail pharmacies.

Many specialty medications are prescribed to treat chronic conditions, meaning that utilizers are likely to use that medication for a long time.

## *Specialty Medications as a Cost Driver*

Specialty medications are one of the largest rising cost drivers in pharmaceutical spend. In the United States in 2008, specialty medications accounted for just over 20% of pharmaceutical spend; by 2023, that percentage is expected to climb to over 50%.<sup>6</sup>

In the AlaskaCare Defined Benefit Retiree Health Plan (Plan), specialty medication use has grown along with its percentage of overall cost. In 2014, specialty medications accounted for 0.7% of total prescriptions and 19% of total Plan pharmacy cost (or \$33.5M out of \$176.7M).<sup>7</sup> In 2020, specialty costs for less than 1% of prescriptions (associated with 3.7% of members utilizing the prescription drug plan, or 3.0% of total Plan members) made up 37%, or \$110 million of the total Plan prescription drug spend. The

---

<sup>1</sup> Pharmaceutical Care Management Association. "What is a Specialty Drug?" <https://www.pcmanet.org/pcma-cardstack/what-is-a-specialty-drug/>

<sup>2</sup> See Attachment B: Characteristics of specialty medications, OptumRx Specialty Pharmacy Drug List, July 1, 2021, page 2.

<sup>3</sup> Affecting fewer than 200,000 people

<sup>4</sup> See Attachment B: Characteristics of specialty medications, OptumRx Specialty Pharmacy Drug List, July 1, 2021, page 2.

<sup>5</sup> Medicare defines drugs with a 30-day equivalent negotiated price of \$670 or more as a specialty drug. [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2021%20mtm%20and%20specialty%20thresholds%20final%20part%20d%20bidding%2005.22.2020\\_8.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/2021%20mtm%20and%20specialty%20thresholds%20final%20part%20d%20bidding%2005.22.2020_8.pdf)

<sup>6</sup> The Global Use of Medicine in 2019 and Outlook to 2023: Forecasts and Areas to Watch. IQVIA Institute. [https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-global-use-of-medicine-in-2019-and-outlook-to-2023.pdf?\\_=1626801058214](https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-global-use-of-medicine-in-2019-and-outlook-to-2023.pdf?_=1626801058214)

<sup>7</sup> 2014 4<sup>th</sup> Quarter AlaskaCare Retiree Health Plan Report, pages 32-33.

Plan’s costs for specialty medications increased \$21 million from 2019 to 2020 (24%), due to increased prescriptions and utilization of higher cost medications.<sup>8</sup>

*Specialty Medication Spend in the AlaskaCare Retiree Plan*

Though specialty drug claims account for less than 1% of all AlaskaCare retiree Plan pharmacy claims in 2020, the \$110 million in Plan costs associated with those prescriptions totaled 37% of the total pharmacy spend. In 2020:<sup>9</sup>

- 60,677 AlaskaCare retiree Plan members filled prescriptions through the Plan’s prescription drug benefit.
- 2,272 individuals (3.7% of all utilizers) filled 10,923 prescriptions for specialty medications.
- Those specialty prescriptions represent less than 1% of the overall 1,380,472 total prescriptions filled by all utilizers.

These medications can have high costs per utilizer, as evidenced by table 1 below.

*Table 1. AlaskaCare Top 5 Specialty Medications for Chronic Conditions, 2020<sup>10</sup>*

Specialty Drug	Average Cost per 30 Day Supply per Individual Utilizer	Average Cost Annually per Individual Utilizer	Total Utilizers in 2020	Average Annual Total Spend*
Humira Pen	\$9,570	\$114,841	166	\$19,063,606
Xeljanz XR	\$9,476	\$113,715	74	\$8,414,910
Enbrel Sureclick	\$10,017	\$120,213	59	\$7,092,567
Jakafi	\$13,369	\$160,439	16	\$2,567,024
Revlimid	\$16,061	\$192,743	60	\$11,564,580

\*Assumes utilizers used the medication for the duration of 2020

*AlaskaCare Retiree Plan Coverage Provisions*

The Plan provides coverage for outpatient prescription drugs for the treatment of an illness, disease, or injury if dispensed upon prescription of a provider acting within the scope of their license.<sup>11</sup> Section 4.5 Medical Necessity under the Prescription Drugs section of the Plan states:

“To be covered under the plan prescription drugs must be medically necessary and clinically appropriate. This provision does not require the use of generic drugs.

The plan will cover some drugs only if prescribed for certain uses, or durations. Certain medications have specific dispensing limitation for quantity, age, gender and maximum dose. Determination of medical necessity will be based on recommendations by the federal Food and Drug Administration (FDA), combined with the pharmacy benefit managers standard coverage policies designed to ensure the medication prescribed is safe and effective. For this reason, some prescription medications may

<sup>8</sup> See Attachment A: OptumRx Presentation, *Retiree Plan Specialty Prior Authorization Opportunity*. June 18, 2021, page 5.

<sup>9</sup> Ibid, page 8.

<sup>10</sup> Ibid, page 4.

<sup>11</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021. Section 4. Prescription Drugs.

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>

be subject to prior authorization to determine that the requested prescription drug is medically necessary.

The prior authorization ensures you are getting the most appropriate care and will occur in the best setting. This helps produce improved health outcomes and lower health care costs by reducing duplication, waste, and unnecessary treatments.”<sup>12</sup>

Prior authorization for prescription drugs is a pharmacy management process that reviews certain medications against clinical, evidence-based standards including those established by the FDA to promote safe and effective use of those medications. Similar to how most medical plans (including the AlaskaCare Defined Benefit Retiree Health Plan) require precertification for certain intensive, complex, and high-cost medical services, prior authorization is a common tool used by pharmacy plans to review dispensation of many different types of medications, including specialty medications.

The Division of Retirement and Benefits (Division) contracts with a Pharmacy Benefit Manager (PBM) – currently OptumRx – to process AlaskaCare prescription drug claims in accordance with the Plan and to apply any appropriate pharmacy management processes.

The prior authorization pharmacy management process is a critical tool for evaluating if the person utilizing a specialty medication meets the medical necessity guidelines outlined by the Plan and established by the FDA and other entities. Without the prior authorization process, the PBM does not have an alternative means to receive and review the information necessary to ensure the patient receiving the medication meets these criteria, including basic diagnostic information.

Currently the Plan does not have this prior authorization process in place for specialty medications. As the use of, and indications for, specialty medications increase, the need for the prior authorization process is becoming acute.

## **2) Objectives**

- a) Promote safe and effective use of medications in accordance with evidence-based clinical standards.
- b) Employ prudent pharmacy management strategies to curtail unnecessary or unsafe utilization of high-cost medications.

## **3) Summary of Proposed Change**

Prior authorization requires prescribers to provide patient-specific medication treatment information for review prior to approval and dispensing to the patient. This review ensures that a prescription drug is medically necessary, appropriately prescribed, meets FDA and other clinical guidelines for the condition being treated, and is therefore eligible for coverage by the Plan. By following clinical standards with use of evidence-based guideline criteria, the prior authorization process promotes safe and effective use of these medications.

---

<sup>12</sup> AlaskaCare Retiree Insurance Information Booklet, January 2021. *Section 4.5 Medical Necessity.*

<http://doa.alaska.gov/drb/pdf/ghlb/retiree/AlaskaCareDBRetireeBooklet2021.pdf>

The Division proposes implementing prior authorization requirements for specialty medications. To do so, the Plan would adopt OptumRx's specialty prior authorization program. Under the proposed program, before the Plan would provide coverage for certain specialty medications, OptumRx must receive and approve a prior authorization for the medication.

#### *Prior Authorization Process*

Providers may submit prior authorization requests electronically, over the phone, or by mail. The prior authorization process is designed with expediency in mind.

Real Time: When appropriate, electronically submitted prior authorizations may be approved in real time through an automated system. Many providers (both in and out of network) have access to OptumRx's PreCheck MyScript tool, an integrated add-on to commonly used Electronic Medical Record (EMR) systems that provides real-time, patient specific drug cost and coverage details. Use of PreCheck MyScript can help ensure that prior authorizations are submitted and approved before the member initiates a prescription fill.

72 Hours: OptumRx processes and provides notice of prior authorization determinations within 72 hours. Initial determination notices may be provided verbally to expedite processing of the prescription, and a written follow-up notice will be mailed within three calendar days. Members can also monitor the status of a prior authorization request on the OptumRx secure portal or mobile app.

24 Hours: Expedited requests are processed, and determination notice is provided within 24 hours.

Because health plans commonly include prior authorization requirements for specialty medications, most clinicians are familiar with the process and are prepared to submit a prior authorization request before the member fills the prescription.

If a required prior authorization is not submitted prior to the member attempting to fill the prescription, when the pharmacy processes the prescription, they will receive a message at the point-of-sale indicating that prior authorization is required. The pharmacy typically notifies the prescribing physician, who is then responsible for submitting the prior authorization request and any associated required additional information.

Once the prior authorization has been submitted, OptumRx will review the prescription against clinical criteria specific to the drug and to the member's condition to ensure safe and effective use of the medication. Members will have the ability to access the clinical criteria specific to their specialty medication via the OptumRx online member portal, or by calling OptumRx customer service.

- If the prior authorization request meets the clinical criteria, it will be approved, and the prescription may be filled.
- If more information is needed, OptumRx will reach out to the prescribing provider.
- If the information provided does not meet clinical criteria, coverage for the prescription will be denied, and information regarding the specific clinical criteria that was not met will be provided to the member.
  - The member may appeal this decision through the AlaskaCare appeals process, or they may work with their prescriber to obtain a different prescription.
  - The member's prescriber may provide additional clinical information to OptumRx to support use of the medication by the member, or they may request a peer-to-peer

discussion with an OptumRx clinical pharmacist to discuss the member's individual condition and circumstances.

Prior authorization approvals are typically valid for 3-36 months, depending on the medication. OptumRx identifies approved prior authorizations expiring within 30 days and will proactively reach out to the prescriber to request any information needed for reauthorization.

If members are unsure if their current medication or any new prescriptions require a prior authorization, they may call OptumRx, consult the Plan's formulary<sup>13</sup> (list of prescribed medications), or review the current OptumRx Specialty Pharmacy Drug List (see attachment B) to determine if their drug is subject to prior authorization.

#### *Development of Prior Authorization Clinical Criteria*

Every PBM has a process for reviewing and aggregating clinical guidelines to establish the clinical criteria used to evaluate prior authorization requests. This proposal contemplates the use of OptumRx's clinical criteria. However, if the plan transitions to a different PBM in the future, that PBM's clinical criteria would be used to evaluate any prior authorizations in effect at that time.

At OptumRx, prior authorization criteria are reviewed and approved by the OptumRx Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is an independent, multi-specialty and nationally represented group of physicians and pharmacists. The P&T Committee evaluates medications based on scientific evidence to find their place in therapy. Quarterly meetings are held to evaluate, review, and make clinical recommendations. Industry, clinical, and company standards govern the P&T Committee's review, consideration, and recommendation processes. The committee considers:

- U.S. Food and Drug Administration (FDA) approved indications
- Manufacturer's package labeling instructions
- Well-accepted and/or published clinical recommendations (ex: American Hospital Formulary Service Drug Information; DRUGDEX; National Comprehensive Cancer Network Drugs and Biologics Compendium; Clinical Pharmacology; major peer reviewed medical journals such as the American Journal of Medicine)

Based on this information, the P&T Committee evaluates whether a drug has a unique therapeutic benefit, comparable safety and efficacy, or whether risk of harm outweighs the benefits. The P&T Committee complies with national quality standards including those provided by the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and the Utilization Review Accreditation Commission (URAC®). After thorough clinical review of prior authorization guidelines is complete, the P&T Committee approves the utilization management criteria.

Actuarial Impact | **Neutral**  
Financial Impact | **Annual Cost Reduction ~\$7.7M**  
Member Impact | **Low**  
Operational Impact (DRB) | **Minimal**  
Operational Impact (TPA) | **Minimal**

---

<sup>13</sup> AlaskaCare formularies are available online: <http://doa.alaska.gov/drb/alaskacare/optumrx.html>

## 4) Impacts

### Actuarial Impact | **Neutral**

This proposal will not result in a change to members' cost share for their covered prescriptions, nor will it remove coverage for any class or drug covered by the plan. Therefore, implementing prior authorizations for specialty medications will not have an impact on the actuarial value of the Plan.<sup>14</sup>

### Financial Impact | **Annual Cost Reduction ~\$7.7M**

#### Cost Saving Potential

Prior authorization is a core component of prudent pharmacy plan management. Medications requiring prior authorization typically have limited FDA-approved uses, are used for conditions that require special diagnostic confirmation, or have a high potential to be prescribed for off-label uses where appropriateness and efficacy are not well established. If left unmanaged without requiring prior authorization, these medications can significantly increase plan costs.

Prior authorizations review medications to ensure safe and effective use. Though cost of the drug is not one of the criteria used to review use of a medication during the prior authorization process, implementation of the prior authorization program is anticipated to bring annual incidental savings to the plan. Plan savings associated with prior authorizations typically fall into four general categories:<sup>15</sup>

1. **Increased Drug Rebates:** The Plan will be eligible to receive increased drug rebates that are provided to plans that adopt prior authorizations. The more favorable rebates are provided regardless of the outcome of any prior authorization requests.
2. **Drug Not Approved:** Some prior authorization requests are not approved because the drug is not appropriate for the member's condition, or because it has been prescribed in a manner contrary to evidence-based guidelines. For example, Xyrem is an orphan drug that is FDA approved to treat narcolepsy but is not covered for chronic fatigue syndrome or fibromyalgia. A prior authorization review would ensure that it has been prescribed to treat an appropriate condition. If an alternative prescription is not written, the cost of the drug is considered savings to the Plan.
3. **Alternative Drug Prescribed:** Some prior authorization requests result in the prescribing physician writing a prescription for an alternative medication. Alternative drugs are not always specialty medications and may not necessarily require a prior authorization. If a prior authorization request results in dispensation of an alternative drug, the difference between the cost of the original medication and the cost of the alternative medication is considered savings to the Plan.
4. **Prescription Abandoned:** Some prior authorization requests are abandoned by the provider or by the member. Examples of abandoned outcomes include the member switching to a non-medication treatment option (*e.g.*, light therapy for psoriasis), the doctor not responding to the prior authorization request from the pharmacy, or the member not taking any action to pursue the prior authorization or fill the prescription. In these instances, the cost of the drug associated with the abandoned prior authorization is considered savings to the plan.

---

<sup>14</sup> *OptumRx Retiree Plan Specialty Prior Authorization Program – Focus on Actuarial and Financial Impact for the Retiree Plan - UPDATED*, Segal memo dated August 27, 2021. (Attachment D).

<sup>15</sup> OptumRx Presentation, Retiree Plan Specialty Prior Authorization Opportunity. June 18, 2021.



### Projected Annual Cost Impact

The financial impact analysis is based on initial savings estimates provided by OptumRx, which were further refined by Segal to account for prescribing and utilization patterns specific to the Plan.

Based on Segal’s preliminary retiree medical and pharmacy claims projection of \$617,000,000 for 2022, the anticipated fiscal impact of this change in 2022 is estimated to be an overall reduction in pharmacy costs of approximately \$7,700,000 (or 1.2% of total projected costs).<sup>16</sup>

Implementing a prior authorization program for specialty medications is anticipated to have an impact on prescription drug claims costs, manufacturer drug rebates, and federal subsidies provided to the Plan through the AlaskaCare enhanced Employer Group Waiver Program (EGWP) Medicare Part D prescription drug plan. The EGWP subsidies are anticipated to reduce by approximately \$2,000,000, but this reduction will be more than offset by the savings associated with claims costs and increased drug rebates.

The projected claims savings are largely due to alternative, more clinically appropriate drugs being prescribed, though some reviews may result in no medications being prescribed. Assuming that over 90% of retirees taking medications on the prior authorization drug list will be approved, the anticipated claims savings for 2022 are \$4,500,000.

Adding prior authorization requirements enables the Plan to access more advantageous drug manufacturer rebate terms. Increased drug rebates associated with the implementation of specialty medication prior authorizations are available to the Plan regardless of whether or not the prior authorization review results in an alternative medication being dispensed. The anticipated rebate increases for 2022 are expected to be \$5,200,000.

Table 2. Projected 2022 Savings Detail<sup>17</sup>

Financial Impact	Non-EGWP	EGWP	Total
2022 Claims Savings	\$1,400,000	\$3,100,000	\$4,500,000
2022 Rebates Changes	\$3,600,000	\$1,600,000	\$5,200,000
2022 EGWP Changes	N/A	(\$2,000,000)	(\$2,000,000)
<b>Total Savings</b>	<b>\$5,000,000</b>	<b>\$2,700,000</b>	<b>\$7,700,000</b>

### Projected Long-Term Cost Impact

The annual cost decrease associated with the proposed prior authorizations may have long-term impacts to the healthcare Actuarial Accrued Liability (AAL)<sup>18</sup> and to the Additional State Contributions (ASC)<sup>19</sup> associated with the Plan.

To estimate the long-term financial impacts of this proposal, Buck considered the estimated 2022 decreases and projected future annual cost decreases using the June 30, 2020 valuation assumptions. Based on these estimates, the AAL would have decreased by approximately \$100.8 million, and the ASC

<sup>16</sup> OptumRx Retiree Plan Specialty Prior Authorization Program – Focus on Actuarial and Financial Impact for the Retiree Plan - UPDATED, Segal memo dated August 27, 2021. (Attachment D).

<sup>17</sup> Ibid.

<sup>18</sup> AAL: The excess of the present value of a pension fund’s total liability for future benefits and fund expenses over the present value of future normal costs for those benefits.

<sup>19</sup> Employer contributions to retirement payments were capped in FY08. Since then, the state makes additional assistance contributions to help cover the accrued unfunded liability associated with participating employers.

for Fiscal Year (FY) 2023 would have decreased by approximately \$1.1 million if these changes had been reflected in the June 30, 2020 valuations.<sup>20</sup>

The ASC provides payment assistance to participating employers' Actuarially Determined Contribution (ADC). The ADC is determined by adding the "Normal Cost"<sup>21</sup> to the amount needed to offset the amortization of any existing unfunded accrued liability over a period of 25 years.

The illustrative decrease to the FY23 ASC is associated with the Normal Cost only. The current overfunded status<sup>22</sup> of the retiree health care liabilities has eliminated the immediate need for amortization payments to offset any health care unfunded liability. It is important to note that the long-term funded status of the trusts is subject to change in response to market volatility and many other factors.

If the retiree health care liabilities were not overfunded, in accordance with the Alaska Retirement Management Board's (ARMB) current funding policy, the total illustrative decrease in the FY23 ASC would be approximately \$7.6 million.<sup>23</sup>

## Member Impact | **Low**

Implementation of prior authorizations for specialty medications will impact a small portion of Plan members. As previously discussed, out of 60,677 members who filled prescription medications in 2020, only 3.7%, or 2,272 individuals, filled prescriptions for specialty medications that would be subject to prior authorization. The Division anticipates the majority of members will continue with their current therapy. Some members may not receive an approval for the prior authorization request for their medication, and those members will need to transition to a different medication or work with their prescriber to provide necessary clinical information to support use of the originally requested medication.

Prescribers will need to complete the prior authorization process for members newly prescribed certain specialty medications after January 1, 2022. Members may contact OptumRx, review individualized information about their prescriptions on the OptumRx.com member portal, or consult the current OptumRx Specialty Pharmacy Drug List (see attachment B) to determine if any of their current medications are specialty medications that are subject to prior authorization. Medications on the list that require a prior authorization are indicated with a "PA" designation after the drug name.

Members who are currently utilizing specialty medications will be notified by mail 60 days in advance of prior authorizations going into effect that a medication they are using will be subject to prior authorization. These members will be advised to speak with their provider, so that the provider is aware

---

<sup>20</sup>Revised Impact of Potential Change in Prior Authorization of Specialty Medications for AlaskaCare Retiree Health Plan, Buck, August 27, 2021.

<sup>21</sup> The normal cost represents the present value of benefits earned by active employees during the current year. The employer normal cost equals the total normal cost of the plan reduced by employee contributions.

<sup>22</sup> Due in part to the savings realized as a result of the 2019 implementation of the enhanced Employer Group Waiver Program (EGWP) group Medicare Part D prescription drug program, the retiree health care liabilities are currently overfunded. The Division's 2020 draft Actuarial Valuation Reports for the Public Employees' Retirement System (PERS) and the Teachers' Retirement System (TRS) indicate that the PERS actuarial funded ratio is 113.5% and the TRS actuarial funded ratio is 121.4%.

<sup>23</sup> Revised Impact of Potential Change in Prior Authorization of Specialty Medications for AlaskaCare Retiree Health Plan, Buck, August 27, 2021.

of the need to submit a prior authorization. Their provider will then initiate the prior authorization through the process described above in section 3.

Members who receive a new prescription for a specialty medication after prior authorizations are implemented will need to work with their prescriber to obtain the relevant prior authorization.

Because most health plans include a requirement for prior authorization for specialty medications, most providers are familiar with the process and are prepared to submit the necessary request and documentation before the member attempts to fill their prescription. In most cases, prior authorization is a process that occurs between the provider and OptumRx, and the member should not have to be heavily involved in the process.

There is no change to coverage for prescription medications that are prescribed under the terms outlined in the Plan booklet. The plan will continue to cover medically necessary and clinically appropriate prescription drugs, and there will be no change to the amount retirees pay for their medications.

### Operational Impact (DRB) | Minimal

To implement this change, the Division will need work with OptumRx to ensure that the prior authorization process is correctly implemented, including auditing and verifying the set-up, creating and executing a member and provider communication campaign, and preparing both the Division and OptumRx’s member services centers to assist members with questions related to prior authorizations.

### Operational Impact (TPA) | Minimal

Prior authorizations for specialty medications are a common plan feature and are included in nearly all commercial and self-insured plans administered by OptumRx. OptumRx has a robust prior authorization department that is already prepared to process any requests, and their member services staff are well versed in the program.

## 5) Proposal Recommendations

### DRB Recommendation

The Division of Retirement and Benefits recommends implementation of this proposal, effective January 1, 2022.

### RHPAB Board Recommendation

Insert the RHPAB recommendation here when final along with any appropriate comments.

Description	Date
Reviewed by Modernization Subcommittee	06/18/2021, 07/28/2021, 08/19/2021
Reviewed by RHPAB	11/05/2020, 08/05/2021, 09/09/2021

### Documents attached include:

Attachment	Document Name
A	OptumRx Presentation, <i>Retiree Plan Specialty Prior Authorization Opportunity</i> , June 18, 2021.
B	OptumRx Specialty Pharmacy Drug List, July 1, 2021

<b>C</b>	OptumRx Presentation, <i>Specialty Prior Authorization</i> , July 28, 2021.
<b>D</b>	<i>OptumRx Retiree Plan Specialty Prior Authorization Program – Focus on Actuarial and Financial Impact for the Retiree Plan - UPDATED</i> , Segal, August 27, 2021
<b>E</b>	<i>Revised Impact of Potential Change in Prior Authorization of Specialty Medications for AlaskaCare Retiree Health Plan</i> , Buck, August 27, 2021.

# Retiree Plan Specialty Prior Authorization Opportunity



# Addressing rising costs and improving outcomes

## RISING PRESCRIPTION COSTS



**Up to \$600B**  
projected drug spend in the  
U.S by 2023<sup>1</sup>

**AFFORDABILITY**

## ADVERSE DRUG EVENTS



Risk of an adverse drug event  
increases by  
**7-10%**  
with each additional medication<sup>2</sup>

**SAFETY**

## SPECIALTY DRUG INCREASE



**More than 2x**  
specialty medication growth  
rate vs. other drugs<sup>3</sup>

**ACCESS**

# Specialty medications dominate spend

## COST

8% year over year growth **\$505B** in spend by 2023<sup>1</sup>

>10% increase in utilization in past four years<sup>1</sup>

~\$52K/year per medication<sup>2</sup>

## COMPLEXITY

### Specialty patients

Take ~10 different medications over the course of a year<sup>3</sup>

Manage ~7 conditions at a time<sup>3</sup>

# Retiree Plan Specialty Drug Costs Per Rx

Specialty medications for chronic conditions

---

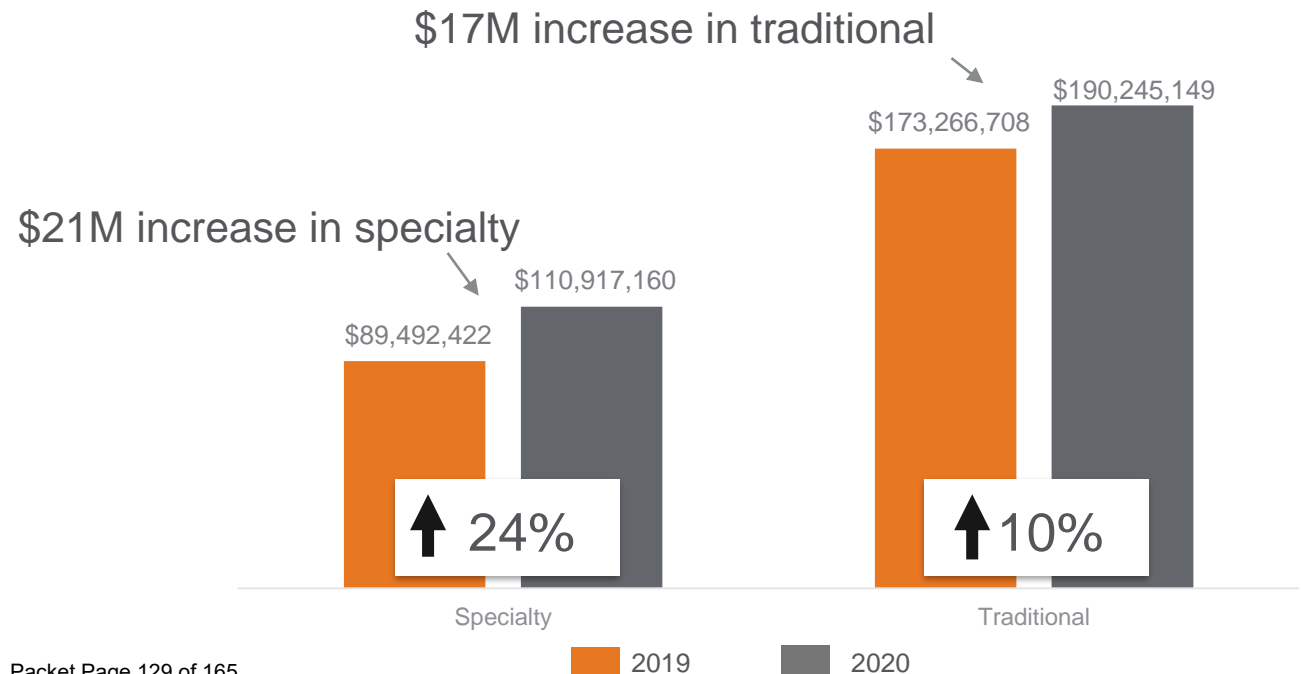
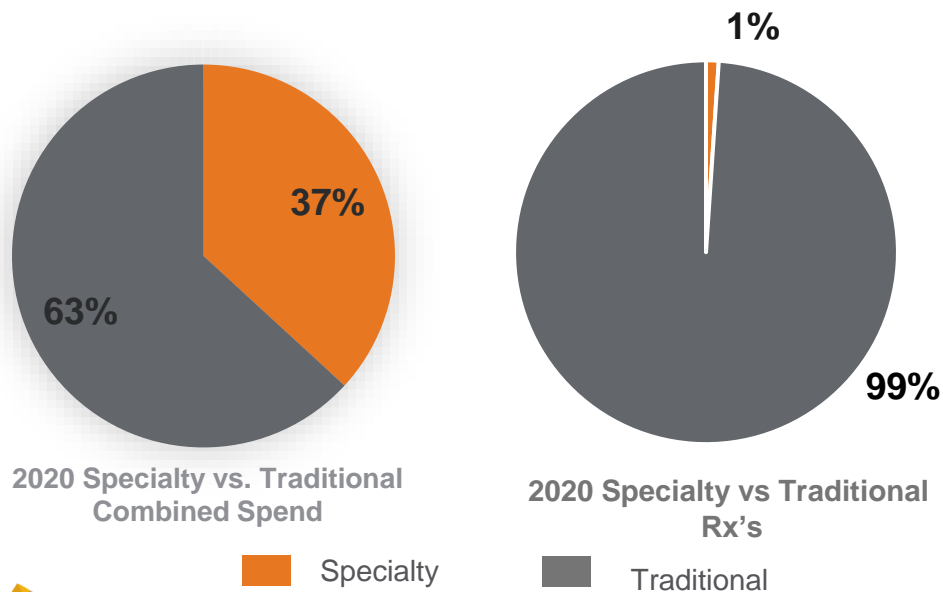
Specialty Drug	Average Cost Per 30 Day Supply <u>Per Utilizer</u>	Average Cost Annually <u>Per Utilizer</u>	Total Number of Utilizers in 2020
Humira Pen	\$9,570	\$114,841	166
Xeljanz XR	\$9,476	\$113,715	74
Enbrel Sureclick	\$10,017	\$120,213	59
Jakafi	\$13,369	\$160,439	16
Revlimid	\$16,061	\$192,743	60



# Retiree Specialty Medication Increases

## 2019 to 2020

- Specialty medication represented 37% of combined retiree total pharmacy spend, or **\$110 M in 2020**
- This was an increase from **\$89M, or 34.1%, in 2019**. This was driven by an increase in specialty Rx's and more costly specialty medications.
- Specialty Rx's represent 1% of the total Rx's.



# What is prior authorization?

A pre-approval process guided by rigorous clinical standards similar to AlaskaCare medical review process for intensive, high-cost medical procedures.



## THE RIGHT DRUG AT THE RIGHT TIME

Your physician provides specific information to OptumRx clinicians to review and compare to evidence-based criteria and clinical standards for the drug



## SAFETY

The process promotes safe and effective use of high-cost medications  
Better health outcomes along with prudent plan management preserves health trust funds



## RETIREE EXPERIENCE

Prior Authorization decisions are communicated to you and your physician  
OptumRx Specialty prior authorization approval rate is 72-77%

# How does OptumRx develop prior authorization?

OptumRx National Pharmacy & Therapeutics Committee

Independent, multi-specialty and nationally represented group of physicians and pharmacists that provides evidence-based review and appraisal of new and existing medications and their place in therapy.

## Multi Specialty



- Internal Medicine
- Epidemiology
- Cardiovascular
- Geriatrics
- Pediatrics
- Endocrinology
- Rheumatology
- Pain Medicine
- Hematology/Oncology

## Nationally Represented



- Northeast
- Southeast
- Midwest
- West
- Southwest

## Responsibilities



- Appraisal of new and existing drugs and drug classes
- Utilization management (prior authorization) program review
- Oversight of clinical programs

## Determinations



- Unique therapeutic benefit
- Comparable safety and efficacy
- Risk of harm outweighs the benefit

# Retiree Plan – Specialty Prior Authorization Savings Opportunity

Estimated annual savings (based on Jan 2020 – Dec 2020 data)

- A total of 60,677 retirees utilized the prescription drug plan in 2020. **2,272 retirees, 3.7% of all utilizers, utilized a specialty medication**
- Specialty Rx’s totaled 10,923, less than 1%, of the overall 1,380,472 prescriptions
- In 2020 **specialty costs increased \$21M, or 24%**

	Total Annual Estimated Savings	Estimated Annual PMPM Savings
Over 65 Retiree	\$8,996,142	\$17.85
Under 65 Retiree	\$4,015,741	\$12.87
<b>Combined Retiree</b>	<b>\$ 13,011,883</b>	<b>\$ 15.95</b>



# Retiree Plan

## A look at the top 5 specialty classes prior authorization opportunity

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Pulmonary Fibrosis	Oncology – Oral Agents
Commonly Used Medications (full drug listing in appendix)	Stelara,, Humira, Taltz, Cosentyx, Xeljanz, Cimzia, Enbrel, Otezla	Tecfidera, Ocrevus, Gilenya, Aubagio, Copaxone, Avonex	Uptravi, Adempas, Orenitram, Letairis, Opsumit	Ofev, Esbriet	Revlimid, Jakafi, Zejula, Calquence, Alecensa, Ninlaro, Idhifa
Utilizers	787	169	83	40	561
Actual Plan Paid	\$35,548,336	\$8,863,490	\$4,135,856	\$2,996,883	\$36,967,233
Average Cost Per Rx in Class	\$8,745	\$10,862	\$9,070	\$11,395	\$12,510
Estimated Plan Reduction	\$3,520,828	\$688,392	\$574,123	\$519,530	\$3,876,799

# Prior Authorization Savings

## What's considered in the savings calculation?

- Some prior authorization requests are not approved because use of the medication is not appropriate and does not meet evidence-based criteria. Actiq prescribed for migraines demonstrates a medication that may not be approved based on criteria. Commonly used drugs and approval rates\*:
  - Humira PA approval rate 86%
  - Revlimid PA approval rate 94%
  - Tecfidera PA approval rate 85%
  - Stelara PA approval rate 65%
- Some prior authorization requests result in the physician writing a prescription for an alternative drug. The difference between the cost of the original medication and the alternative is considered savings.
- Some prior authorization requests are abandoned by the physician or patient. The cost of the drug associated with the abandoned prior authorization is considered savings.

## Example: Actiq®



**COVERED**  
for cancer pain

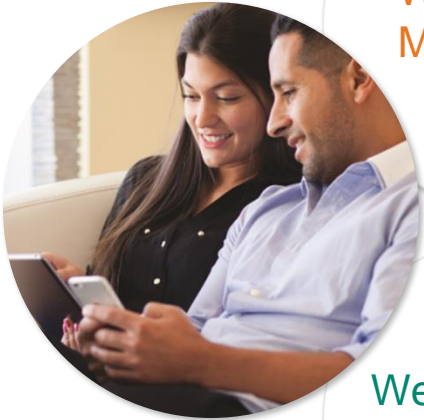
FDA-approved for treating cancer-related pain in members already taking opioid medication around-the-clock



**NOT COVERED**  
for migraines

Contraindicated in the management of acute or post-operative pain including migraines

# Enhance the member and provider experience with sophisticated digital tools



We support  
Members by:

- Giving them **control** to **initiate or check the status** of a PA request through our **website** and **mobile app**
- Offering **MyScript Finder** to look up **details, costs** and **formulary-driven lower-cost alternatives**
- **Providing clinical rationale** and next steps if they experience a denial

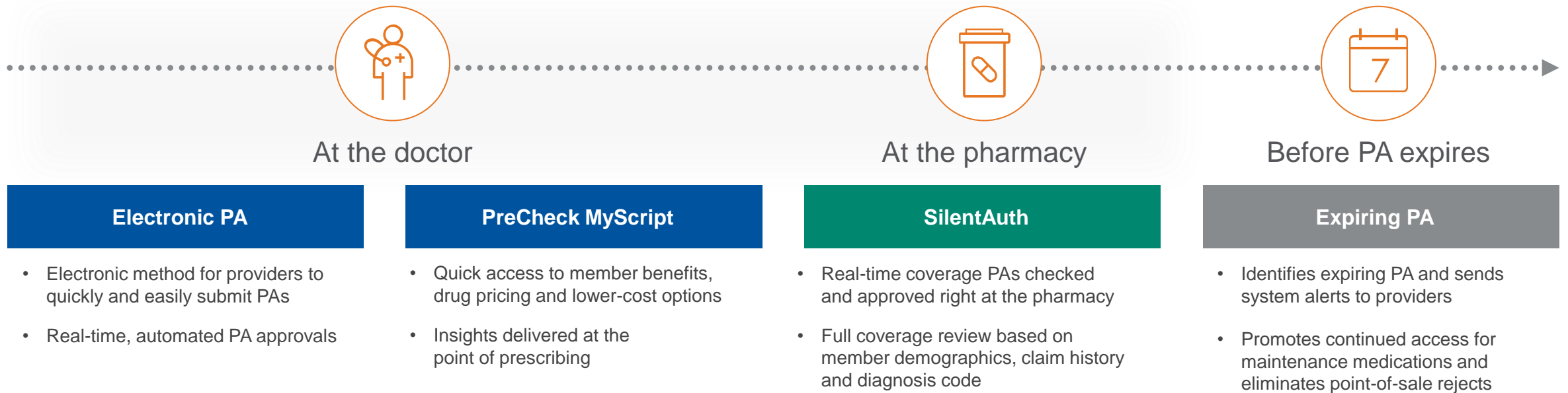
We support  
Physicians by:

- The use of our **provider portal** allows providers to **check PA status**
- Offering the **PreCheck MyScript®** tool to **initiate authorizations** and give **formulary-driven alternatives** in **real-time**. In 2020, 12,597 physicians treating AlaskaCare retirees utilized **PreCheck MyScript®**.

# Prescriber experience and tools

Faster prescribing, better communication, continued access

Prior authorization (PA) capabilities work together to improve the provider and member experience





# Member experience

Prior authorization review is needed to ensure appropriate and effective medication use for the member's specific condition

Member receives notification letter 60 days in advance advising their medication will be subject to prior authorization



Member discusses the medication subject to prior authorization with their prescriber



Prescriber initiates prior authorization with OptumRx in one of three methods: electronic, phone or mail submission



Coverage is approved\* and member can fill at their preferred pharmacy



## Coverage Determinations

OptumRx will provide notice of the coverage decision within 24 hours after receiving an expedited request or 72 hours after receiving a standard request. The initial notice may be provided verbally so long as a written follow-up notice is mailed to the enrollee within 3 calendar days of the verbal notification.

## Expiring Prior Authorizations

OptumRx identifies approved prior authorizations for prescriptions expiring within 30 days and initiates outreach to prescriber to extend prior authorization proactively, taking the member out the middle.

Clinical criteria is not met for coverage approval and member and prescriber are notified in writing with decision rationale and next steps for reconsideration



Provider writes new prescription for alternative medication or proceeds with next steps for reconsideration through OptumRx



# Retiree Journey: Barbara's story

## Prior authorization promotes safe and effective medication use



Barbara, age 61 diagnosed with multiple sclerosis



Electronic Prior Authorization (ePA) saves time and avoids unnecessary delays.



Barbara can check real-time status through our website and mobile app.

1

Barbara is prescribed **Gilenya** by her physician and the pharmacy receives her electronic prescription.

2

The pharmacy processes the prescription and **receives a utilization management message indicating "prior authorization (PA) required."**

3

The pharmacy notifies Barbara's physician that a PA is required and the **physician submits an ePA to OptumRx.**

4

The PA request **meets clinical criteria and is auto-approved** with no additional information required.

5

**Barbara's physician is notified of the PA approval.**

The **pharmacy re-submits the claim to OptumRx and the claim is approved.**

Barbara receives PA approval notification via letter from OptumRx.

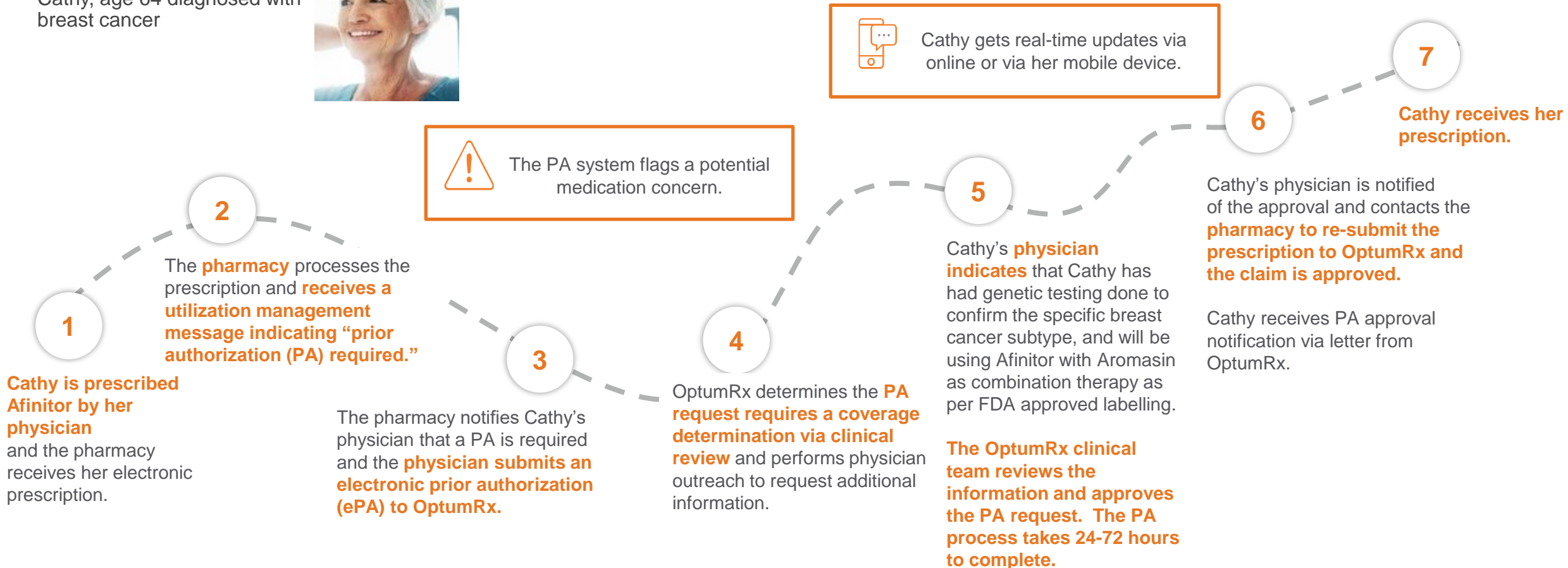
6

**Barbara receives her prescription.**

# Retiree Journey: Cathy's story

## Clinical rigor helps to ensure members receive the right medications

Cathy, age 64 diagnosed with breast cancer



# Specialty Management Savings Opportunity Summary

- ✓ A total of 60,677 retirees utilized the prescription drug plan in 2020. Retirees who filled for a specialty medication represented 2,272, or 3.7%, of that total.
- ✓ Specialty Rx's totaled 10,923, or less than 1%, of the overall 1,380,472 prescriptions
- ✓ Specialty represented 37% of the total retiree pharmacy spend
- ✓ Retiree plan specialty costs increased \$21M in 2020, or 24%, based on increased Rx's and higher cost specialty medications being utilized
- ✓ Implementing specialty prior authorization would save an estimated **\$13M**

# Appendix



# Top 5 Specialty Class Prior Authorization Opportunities

## Medication list

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Pulmonary Fibrosis	Oncology – Oral Agents
Medications	Actemra, Avsola, Cimzia, Cosentyx, Enbrel, Enbrel Mini, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Renflexis, Remicade, Rinvoq, Siliq, Simponi, Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz, Xeljanz XR	Ampyra, Avonex, Aubagio, Bafiertam, Betaseron, Extavia, Copaxone, Gilenya, Glatopa, Lemtrada, Mavenclad, Mayzent, Novantrone, Ocrevus, Plegridy, Rebif, Tecfidera, Tysabri, Vumerity, Zeposia	Adcirca, Adempas, Alyq, Flolan, Letairis, Opsumit, Orenitram, Remodulin, Revatio, Tracleer, Tyvaso, Uptravi, Veletri, Ventavis	Esbriet, Ofev	Afinitor, Afinitor Disperz, Alecensa, Alunbrig, Ayvakit, Balversa, Bosulif, Braftovi, Brukinsa, Cabometyx, Calquence, Caprelsa, Cometriq, Copiktra, Cotellic, Daurismo, Erivedge, Erleada, Farydak, Gilotrif, Gleevec, Ibrance, Iclusig, IDHIFA, Imbruvica, Inlyta, Inrebic, Iressa, Jakafi, Kisqali, Kisqali Femara, Koselugo, Lenvima, Lonsurf, Lorbrina, Lynparza, Mekinist, Mektovi, Nerlynx, Nexavar, Ninlara, Nubeqa, Odomzo, Pemazyre, Piqray, Pomalyst, Qinlock, Retevmo, Revlimid, Rozlytrek, Rubraca, Rydapt, Sprycel, Stivarga, Sutent, Tabrecta, Tafinlar, Tagrisso, Talzenna, Tarceva, Targretin, Tassigna, Tazverik, Temodar, Thalomid, Tibsovo, Tukysa, Turalio, Tykerb, Venclexta, Verzenio, Vitakvi, Vizimpro, Votrient, Xalkori, Xeloda, Xospata, Xpovio, Xtandi, Yonsa, Zejula, Zelboraf, Zolanza, Zydelig, Zykadia, Zytiga

# Non-EGWP (Under 65) Retiree Plan

A look at the top 5 specialty classes with prior authorization opportunity (Jan 2020 – Dec 2020)

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Osteoporosis	Oncology – Oral Agents
Example Medications (full drug listing in appendix)	Stelara,, Humira, Taltz, Cosentyx, Xeljanz, Cimzia, Enbrel, Otezla	Tecfidera, Ocrevus, Gilenya, Aubagio, Copaxone, Avonex	Uptravi, Adempas, Orenitram, Letairis, Opsumit	Forteo, Prolia, Xgeva, Tymlos, Evenity	Revlimid, Jakafi, Zejula, Calquence, Alecensa, Ninlaro, Idhifa
Utilizers	307	79	5	75	121
Actual Plan Paid	\$13,405,897	\$3,954,684	\$1,290,256	\$634,985	\$5,948,179
Actual Plan Paid per Rx	\$8,004	\$10,894	\$26,332	\$3,097	\$10,273
Estimated Plan Reduction	\$1,147,215	\$302,200	\$123,803	\$202,747	\$725,076

# EGWP (Over 65) Retiree Plan

A look at the top 5 specialty classes with prior authorization opportunity (Jan 2020 – Dec 2020)

	Anti-Inflammatory Biologic Agents	Multiple Sclerosis	Pulmonary Hypertension	Pulmonary Fibrosis	Oncology – Oral Agents
Example Medications (full drug listing in appendix)	Cimzia, Cosentyx, Enbrel, Humira, Skyrizi, Stelara, Taltz, Tremfya, Xeljanz	Copaxone, Gilenya, Ocrevus, Rebif, Tecfidera, Tysabri	Letairis, Revatio, Tracleer, Tyvaso, Upravi	Ofev, Esbriet	Bosulif, Gleevec, Ibrance, Imbruvica, Jakafi, Mekinist, Revlimid, Sprycel, Tagrisso, Tassigna, Verzenio, Xospata
Utilizers	480	90	78	34	440
Actual Plan Paid	\$22,142,439	\$4,908,806	\$2,845,600	\$2,661,737	\$31,019,054
Actual Plan Paid per Rx	\$9,135	\$10,836	\$6,992	\$11,137	\$13,050
Estimated Plan Reduction	\$2,373,613	\$386,192	\$450,320	\$455,586	\$3,151,723



## Specialty pharmacy drug list

July 1, 2021



Optum<sup>®</sup> Specialty Pharmacy provides specialty medication support through your pharmacy benefits with OptumRx. Optum Specialty Pharmacy provides comprehensive support services, including access to pharmacists around the clock, for high-cost oral and injectable medications used to treat rare and complex conditions. In addition, your medications will be shipped to you at no extra cost.

## Characteristics of specialty medications

Specialty medications are often drugs you take by mouth or inject. For a medication to be filled through Optum Specialty Pharmacy, it must be at least one of the following:

### High-priced

- Can cost more than \$1,000/30 day supply.

### Complex

- Drug imitates compounds found in the body.
- Part of a specialty drug class.

### High-touch

- Special shipping or handling like refrigeration.
- Needs a doctor or pharmacist to measure how well it works for you.
- Special steps to follow as you take.

# Specialty pharmacy drug list

## Adult incontinence

Solesta

## Ammonia detoxicants

Ravicti <sup>PA</sup>

## Anemia

Aranesp <sup>PA</sup>

Epogen <sup>PA</sup>

Mircera <sup>PA</sup>

Procrit <sup>PA</sup>

Reblozyl <sup>PA</sup>

Retacrit <sup>PA</sup>

## Antibacterials

Arikayce <sup>PA</sup>

## Anticoagulation

Arixtra

Fragmin

Lovenox

## Anticovulsants

Diacomit <sup>PA</sup>

Epidiolex <sup>PA</sup>

Fintepla <sup>PA</sup>

## Anti-gout agent

Krystexxa <sup>PA</sup>

## Antihyperlipidemic

Evkeeza

Juxtapid <sup>PA</sup>

## Anti-infective

Daraprim <sup>PA</sup>

Prevymis

## Asthma

Cinqair <sup>PA</sup>

Fasenra <sup>PA</sup>

Nucala <sup>PA</sup>

Xolair <sup>PA</sup>

## Cardiovascular

Northera <sup>PA</sup>

Vyndamax <sup>PA</sup>

Vyndaqel <sup>PA</sup>

## Central nervous system agents

Austedo <sup>PA</sup>

Brineura <sup>PA</sup>

Enspryng <sup>PA</sup>

Firdapse <sup>PA</sup>

Hetlioz <sup>PA</sup>

Ingrezza <sup>PA</sup>

Radicava <sup>PA</sup>

Ruzurgi <sup>PA</sup>

Sabril <sup>PA</sup>

Tiglutik <sup>PA</sup>

Uplizna <sup>PA</sup>

Xenazine <sup>PA</sup>

## Chemotherapy protectant

Elitek

## Cystic fibrosis

Bethkis

Cayston <sup>PA</sup>

Kalydeco <sup>PA</sup>

Kitabis pak

Orkambi <sup>PA</sup>

Pulmozyme <sup>PA</sup>

Symdeko <sup>PA</sup>

Tobi

Tobi Podhalr

Tobramycin

Trikafta <sup>PA</sup>

## Dermatologic

Scenesse <sup>PA</sup>

## Diagnostic

Acthrel

## Duchenne muscular dystrophy

Amondys 45

Emflaza <sup>PA</sup>

## Endocrine

Bynfezia Pen <sup>PA</sup>

Chenodal <sup>PA</sup>

Crysvita <sup>PA</sup>

Cuprimine <sup>PA</sup>

Cystadane

Depen Titra

Egrifta <sup>PA</sup>

Firmagon <sup>PA</sup>

Imcivree

Isturisa <sup>PA</sup>

Jynarque

Korlym <sup>PA</sup>

Kuvan <sup>PA</sup>

Lupaneta <sup>PA</sup>

Lupron Depot <sup>PA</sup>

Makena <sup>PA</sup>

Myalept <sup>PA</sup>

Mycapssa <sup>PA</sup>

Natpara <sup>PA</sup>

Nityr <sup>PA</sup>

Parsabiv

Procysbi <sup>PA</sup>

Samsca

Sandostatin <sup>PA</sup>

Signifor <sup>PA</sup>

Somatuline <sup>PA</sup>

Somavert <sup>PA</sup>

Supprelin LA <sup>PA</sup>

Syprine <sup>PA</sup>

Tepezza <sup>PA</sup>

Thiola

Thyrogen <sup>PA</sup>

Triptodur <sup>PA</sup>

Xuriden <sup>PA</sup>

## Enzyme therapy

Aldurazyme <sup>PA</sup>

Aralast NP <sup>PA</sup>

Buphenyl

Carbaglu

Cerdelga <sup>PA</sup>

Cerezyme <sup>PA</sup>

Cholbam <sup>PA</sup>

Cystagon

Elaprase <sup>PA</sup>

Elelyso <sup>PA</sup>

Fabrazyme <sup>PA</sup>

Galafold <sup>PA</sup>

Givlaari <sup>PA</sup>

Glassia <sup>PA</sup>

Kanuma <sup>PA</sup>

Lumizyme <sup>PA</sup>

Mepsevii <sup>PA</sup>

Naglazyme <sup>PA</sup>

Onpattro <sup>PA</sup>

Orfadin <sup>PA</sup>

Palynziq <sup>PA</sup>

Prolastin-C <sup>PA</sup>

Revcovi <sup>PA</sup>

# Specialty pharmacy drug list

Strensiq<sup>PA</sup>  
 Sucraid  
 Tegsedi<sup>PA</sup>  
 Vimizim<sup>PA</sup>  
 Vpriv<sup>PA</sup>  
 Zavesca<sup>PA</sup>  
 Zemaira<sup>PA</sup>

## Gastrointestinal agents

Gattex<sup>PA</sup>  
 Ocaliva<sup>PA</sup>  
 Xermelo<sup>PA</sup>

## Gene therapy

Zolgensma<sup>PA</sup>

## Growth hormone deficiency

Genotropin<sup>PA</sup>  
 Humatrope<sup>PA</sup>  
 Increlex<sup>PA</sup>  
 Norditropin<sup>PA</sup>  
 Nutropin AQ<sup>PA</sup>  
 Omnitrope<sup>PA</sup>  
 Saizen<sup>PA</sup>  
 Serostim<sup>PA</sup>  
 Zomacton<sup>PA</sup>  
 Zorbtive<sup>PA</sup>

## Hematological agents

Adakveo<sup>PA</sup>  
 Cablivi<sup>PA</sup>  
 Doptelet<sup>PA</sup>  
 Fibryga  
 Mozobil<sup>PA</sup>  
 Mulpleta<sup>PA</sup>  
 Nplate<sup>PA</sup>  
 Oxbryta<sup>PA</sup>

Panhematin  
 Promacta<sup>PA</sup>  
 Riastap  
 Soliris<sup>PA</sup>  
 Tavalisse<sup>PA</sup>  
 Thrombat III  
 Ultomiris<sup>PA</sup>

## Hemophilia

Advate  
 Adynovate  
 Afstyla  
 Alphanate  
 Alphanine SD  
 Alprolix  
 Benefix  
 Ceprotin  
 Coagadex  
 Corifact  
 Eloctate  
 Esperoct  
 Feiba  
 Helixate FS  
 Hemlibra  
 Hemofil M  
 Humate-P  
 Idelvion  
 Ixinity  
 Jivi  
 Koate  
 Koate-DVI  
 Kogenate FS  
 Kovaltry  
 Mononine  
 Novoeight  
 Novoseven RT  
 Nuwiq  
 Obizur

Profilnine  
 Rebinyn  
 Recombinate  
 Rixubis  
 Sevenfact  
 Tretten  
 Vonvendi  
 Wilate  
 Xyntha

## Hepatitis B

Baraclude  
 Epiriv HBV  
 Hepsera  
 Vemlidy

## Hepatitis C

Eplclusa<sup>PA</sup>  
 Harvoni<sup>PA</sup>  
 Ledip-Sofosb<sup>PA</sup>  
 Mavyret<sup>PA</sup>  
 Pegasys<sup>PA</sup>  
 Peg-Intron<sup>PA</sup>  
 Ribavirin  
 Sofos/Velpat<sup>PA</sup>  
 Sovaldi<sup>PA</sup>  
 Technivie  
 Viekira<sup>PA</sup>  
 Vosevi<sup>PA</sup>  
 Zepatier<sup>PA</sup>

## Hereditary angioedema

Berinert<sup>PA</sup>  
 Cinryze<sup>PA</sup>  
 Firazyr<sup>PA</sup>  
 Haegarda<sup>PA</sup>  
 Kalbitor<sup>PA</sup>  
 Orladeyo

Ruconest<sup>PA</sup>  
 Takhzyro<sup>PA</sup>

## Immune globulin

Asceniv<sup>PA</sup>  
 Bivigam<sup>PA</sup>  
 Carimune NF<sup>PA</sup>  
 Cutaquig<sup>PA</sup>  
 Cuvitru<sup>PA</sup>  
 Cytogam<sup>PA</sup>  
 Flebogamma<sup>PA</sup>  
 Gamastan S/D<sup>PA</sup>  
 Gammagard<sup>PA</sup>  
 Gammaked<sup>PA</sup>  
 Gammaplex<sup>PA</sup>  
 Gamunex-C<sup>PA</sup>  
 Hizentra<sup>PA</sup>  
 Hyperrho S/D  
 Hyqvia<sup>PA</sup>  
 Micrhogam  
 Octagam<sup>PA</sup>  
 Panzyga<sup>PA</sup>  
 Privigen<sup>PA</sup>  
 Rhogam  
 Winrho SDF  
 Xembify<sup>PA</sup>

## Immunological agents

Actimmune<sup>PA</sup>  
 Arcalyst<sup>PA</sup>  
 Benlysta<sup>PA</sup>  
 Gamifant<sup>PA</sup>  
 Illaris<sup>PA</sup>  
 Lemtrada<sup>PA</sup>  
 Lupkynis

Palforzia <sup>PA</sup>

### Infertility

Cetrotide <sup>PA</sup>  
Follistim AQ <sup>PA</sup>  
Ganirelix <sup>PA</sup>  
Gonal-F <sup>PA</sup>  
HCG <sup>PA</sup>  
Menopur <sup>PA</sup>  
Novarel <sup>PA</sup>  
Ovidrel  
Pregnyl <sup>PA</sup>

### Inflammatory conditions

Actemra <sup>PA</sup>  
Avsola <sup>PA</sup>  
Cimzia <sup>PA</sup>  
Cosentyx <sup>PA</sup>  
Dupixent <sup>PA</sup>  
Enbrel <sup>PA</sup>  
Entyvio <sup>PA</sup>  
H.P.Acthar <sup>PA</sup>  
Humira <sup>PA</sup>  
Ilumya <sup>PA</sup>  
Inflectra <sup>PA</sup>  
Kevzara <sup>PA</sup>  
Kineret <sup>PA</sup>  
Olumiant <sup>PA</sup>  
Orencia <sup>PA</sup>  
Otezla <sup>PA</sup>  
Remicade <sup>PA</sup>  
Renflexis <sup>PA</sup>  
Ridaura  
Rinvoq <sup>PA</sup>  
Siliq <sup>PA</sup>  
Simponi <sup>PA</sup>  
Skyrizi  
Stelara <sup>PA</sup>

Taltz <sup>PA</sup>  
Tremfya <sup>PA</sup>  
Xeljanz <sup>PA</sup>

### Metabolic agents

Nulibry

### Metabolic bone disease

Reclast

### Mood disorder

Spavato <sup>PA</sup>  
Zulresso <sup>PA</sup>

### Multiple sclerosis

Ampyra <sup>PA</sup>  
Aubagio <sup>PA</sup>  
Avonex <sup>PA</sup>  
Bafiertam <sup>PA</sup>  
Betaseron <sup>PA</sup>  
Copaxone <sup>PA</sup>  
Extavia <sup>PA</sup>  
Gilenya <sup>PA</sup>  
Kesimpta <sup>PA</sup>  
Mavenclad <sup>PA</sup>  
Mayzent <sup>PA</sup>  
Ocrevus <sup>PA</sup>  
Plegridy <sup>PA</sup>  
Ponvory  
Rebif <sup>PA</sup>  
Tecfidera <sup>PA</sup>  
Tysabri <sup>PA</sup>  
Vumerity <sup>PA</sup>  
Zeposia <sup>PA</sup>

### Musculoskeletal agents

Botox Cosmet <sup>PA</sup>  
Evrysti <sup>PA</sup>

Exondys 51 <sup>PA</sup>  
Spinraza <sup>PA</sup>  
Viltepso  
Vyondys 53  
Xiaflex <sup>PA</sup>

### Narcolepsy

Wakix <sup>PA</sup>  
Xyrem <sup>PA</sup>  
Xywav <sup>PA</sup>

### Neurological agents

Botox <sup>PA</sup>  
Dysport <sup>PA</sup>  
Myobloc <sup>PA</sup>  
Xeomin <sup>PA</sup>

### Neutropenia

Fulphila <sup>PA</sup>  
Granix <sup>PA</sup>  
Leukine <sup>PA</sup>  
Neulasta <sup>PA</sup>  
Neupogen <sup>PA</sup>  
Nivestym <sup>PA</sup>  
Nyvepria  
Udenyca <sup>PA</sup>  
Zarxio <sup>PA</sup>  
Ziextenzo <sup>PA</sup>

### Oncology - injectable

Abecma  
Abraxane  
Adcetris <sup>PA</sup>  
Adriamycin  
Adrucil  
Alferon N  
Alimta  
Aliqopa <sup>PA</sup>

Alkeran  
Arranon  
Arzerra <sup>PA</sup>  
Asparlas  
Avastin <sup>PA</sup>  
Bavencio <sup>PA</sup>  
Beleodaq <sup>PA</sup>  
Belrapzo <sup>PA</sup>  
Bendamustine <sup>PA</sup>  
BendeKa <sup>PA</sup>  
Besponsa <sup>PA</sup>  
Bicnu  
Blenrep <sup>PA</sup>  
Bleomycin  
Blinicyto <sup>PA</sup>  
Bortezomib <sup>PA</sup>  
Busulfex  
Breyanzi  
Campath  
Camptosar  
Carboplatin  
Cisplatin Injectable  
Cladribine  
Clolar  
Cosela  
Cosmegen  
Cyclophosphamide  
Cyramza <sup>PA</sup>  
Cytarabine  
Dacogen <sup>PA</sup>  
Danyelza  
Darzalex <sup>PA</sup>  
Daunorubicin  
Docetaxel  
Doxil  
Doxorubicin  
Eligard <sup>PA</sup>  
Ellence  
Elzonris <sup>PA</sup>

# Specialty pharmacy drug list

Empliciti <sup>PA</sup>	Libtayo <sup>PA</sup>	Tecentriq <sup>PA</sup>	Balversa <sup>PA</sup>
Enhertu <sup>PA</sup>	Lumoxiti <sup>PA</sup>	Temodar <sup>PA</sup>	Bosulif <sup>PA</sup>
Erbix <sup>PA</sup>	Lupron Depot <sup>PA</sup>	Tepadina	Braftovi <sup>PA</sup>
Erwinaze	Margenza	Thiotepa	Brukina <sup>PA</sup>
Etopophos	Marqibo	Tice BCG	Cabometyx <sup>PA</sup>
Etoposide Injectable	Mesnex	Torisel	Calquence <sup>PA</sup>
Evomela	Mitomycin Injectable	Totect	Caprelsa <sup>PA</sup>
Faslodex	Monjuvi <sup>PA</sup>	Trazimera <sup>PA</sup>	Cometriq <sup>PA</sup>
Fensolvi <sup>PA</sup>	Mvasi <sup>PA</sup>	Treanda	Copiktra <sup>PA</sup>
Fludarabine	Mylotarg <sup>PA</sup>	Trelstar mix <sup>PA</sup>	Cotellic <sup>PA</sup>
Fluorouracil Injectable	Navelbine	Trisenox	Daurismo <sup>PA</sup>
Foloty <sup>PA</sup>	Nipent	Trodely <sup>PA</sup>	Erivedge <sup>PA</sup>
Fusilev	Ogivri <sup>PA</sup>	Truxima <sup>PA</sup>	Erleada <sup>PA</sup>
Gazyva <sup>PA</sup>	Oncaspar	Unituxin <sup>PA</sup>	Etoposide Capsule
Halaven <sup>PA</sup>	Onivyde	Valstar	Farydak <sup>PA</sup>
Herceptin <sup>PA</sup>	Ontruzant <sup>PA</sup>	Vantas <sup>PA</sup>	Fotivda
Herzuma <sup>PA</sup>	Opdivo <sup>PA</sup>	Vectibix	Gavreto <sup>PA</sup>
Hycamtin	Padcev <sup>PA</sup>	Velcade <sup>PA</sup>	Gilotrif <sup>PA</sup>
Idamycin PFS	Pamidronate	Vidaza	Gleevec <sup>PA</sup>
Ifex	Paraplatin	Vinblastine Injectable	Gleostine
Ifosfamide	Pepaxto	Vyxeos <sup>PA</sup>	Hycamtin
Imfinzi <sup>PA</sup>	Perjeta <sup>PA</sup>	Xgeva <sup>PA</sup>	Ibrance <sup>PA</sup>
Imlygic	Phesgo <sup>PA</sup>	Yervoy <sup>PA</sup>	Iclusig <sup>PA</sup>
Infugem	Photofrin	Yescarta <sup>PA</sup>	Idhifa <sup>PA</sup>
Intron A <sup>PA</sup>	Polivy <sup>PA</sup>	Yondelis	Imbruvica <sup>PA</sup>
Istodax OVR <sup>PA</sup>	Portrazza <sup>PA</sup>	Zaltrap <sup>PA</sup>	Inlyta <sup>PA</sup>
Ixempra kit	Poteligeo <sup>PA</sup>	Zanosar	Inqovi <sup>PA</sup>
Jelmyto	Proleukin	Zepzelca <sup>PA</sup>	Inrebic <sup>PA</sup>
Jevtana <sup>PA</sup>	Provenge <sup>PA</sup>	Zevalin	Iressa <sup>PA</sup>
Kadcyla <sup>PA</sup>	Riabni	Zinecard	Jakafi <sup>PA</sup>
Kanjinti <sup>PA</sup>	Rituxan <sup>PA</sup>	Zirabev <sup>PA</sup>	Kisqali <sup>PA</sup>
Kepivance	Romidepsin <sup>PA</sup>	Zoladex	Koselugo <sup>PA</sup>
Keytruda <sup>PA</sup>	Ruxience <sup>PA</sup>	<b>Oncology - oral</b>	Lenvima <sup>PA</sup>
Khapzory <sup>PA</sup>	Sarclisa <sup>PA</sup>	Afinitor <sup>PA</sup>	Lonsurf <sup>PA</sup>
Kymriah <sup>PA</sup>	Sylatron <sup>PA</sup>	Alecensa <sup>PA</sup>	Lorbrena <sup>PA</sup>
Kyprolis <sup>PA</sup>	Sylvant <sup>PA</sup>	Alkeran	Lynparza <sup>PA</sup>
Lartruvo <sup>PA</sup>	Synribo <sup>PA</sup>	Alunbrig <sup>PA</sup>	Matulane
Leuprolide Injectable <sup>PA</sup>	Taxotere	Ayvakit <sup>PA</sup>	Mekinist <sup>PA</sup>
Levoleucovor	Tecartus <sup>PA</sup>		Mektovi <sup>PA</sup>

Mesnex  
Nerlynx <sup>PA</sup>  
Nexavar <sup>PA</sup>  
Nilandron  
Ninlaro <sup>PA</sup>  
Nubeqa <sup>PA</sup>  
Odomzo <sup>PA</sup>  
Onureg <sup>PA</sup>  
Orgovyx  
Pemazyre <sup>PA</sup>  
Piqray <sup>PA</sup>  
Pomalyst <sup>PA</sup>  
Purixan  
Qinlock <sup>PA</sup>  
Retevmo <sup>PA</sup>  
Revlimid <sup>PA</sup>  
Rozlytrek <sup>PA</sup>  
Rubraca <sup>PA</sup>  
Rydapt <sup>PA</sup>  
Sprycel <sup>PA</sup>  
Stivarga <sup>PA</sup>  
Sutent <sup>PA</sup>  
Tabloid  
Tabrecta <sup>PA</sup>  
Tafinlar <sup>PA</sup>  
Tagrisso <sup>PA</sup>  
Talzenna <sup>PA</sup>  
Tarceva <sup>PA</sup>  
Targretin <sup>PA</sup>  
Tasigna <sup>PA</sup>  
Tazverik <sup>PA</sup>  
Temodar <sup>PA</sup>  
Tepmetko  
Thalomid <sup>PA</sup>  
Tibsovo <sup>PA</sup>  
Tukysa <sup>PA</sup>  
Turalio <sup>PA</sup>  
Tykerb <sup>PA</sup>  
Ukoniq  
Venclexta <sup>PA</sup>

Verzenio <sup>PA</sup>  
Vitrakvi <sup>PA</sup>  
Vizimpro <sup>PA</sup>  
Votrient <sup>PA</sup>  
Xalkori <sup>PA</sup>  
Xeloda <sup>PA</sup>  
Xospata <sup>PA</sup>  
Xpovio <sup>PA</sup>  
Xtandi <sup>PA</sup>  
Yonsa <sup>PA</sup>  
Zejula <sup>PA</sup>  
Zelboraf <sup>PA</sup>  
Zolinza <sup>PA</sup>  
Zydelig <sup>PA</sup>  
Zykadia <sup>PA</sup>  
Zytiga <sup>PA</sup>

### **Oncology - topical**

Targretin Gel <sup>PA</sup>  
Valchlor <sup>PA</sup>

### **Ophthalmic agents**

Beovu <sup>PA</sup>  
Bevacizumab  
Cystadrops <sup>PA</sup>  
Cystaran <sup>PA</sup>  
Dextenza  
Eylea <sup>PA</sup>  
Iluvien  
Jetrea  
Keveyis <sup>PA</sup>  
Lucentis <sup>PA</sup>  
Luxtorna <sup>PA</sup>  
Macugen <sup>PA</sup>  
Oxervate <sup>PA</sup>  
Ozurdex  
Retisert  
Visudyne  
Yutiq

### **Opioid antagonists**

Sublocade

### **Osteoarthritis**

Durolane <sup>PA</sup>  
Euflexxa <sup>PA</sup>  
Gel-one <sup>PA</sup>  
Gelsyn-3 <sup>PA</sup>  
Genvisc 850 <sup>PA</sup>  
Hymovis <sup>PA</sup>  
Monovisc <sup>PA</sup>  
Orthovisc <sup>PA</sup>  
Sodium Hyalu <sup>PA</sup>  
Supartz <sup>PA</sup>  
Synvisc <sup>PA</sup>  
Triluron <sup>PA</sup>  
Trivisc <sup>PA</sup>  
Visco-3 <sup>PA</sup>

### **Osteoporosis**

Evenity <sup>PA</sup>  
Forteo <sup>PA</sup>  
Prolia <sup>PA</sup>  
Teriparatide <sup>PA</sup>  
Tymlos <sup>PA</sup>

### **Pain management**

Prialt

### **Parkinson's disease**

Apokyn <sup>PA</sup>  
Inbrija <sup>PA</sup>  
Kynmobi <sup>PA</sup>

### **Pulmonary fibrosis**

Esbriet <sup>PA</sup>

Ofev <sup>PA</sup>

### **Pulmonary hypertension**

Adcirca <sup>PA</sup>  
Adempas <sup>PA</sup>  
Flolan <sup>PA</sup>  
Letairis <sup>PA</sup>  
Opsumit <sup>PA</sup>  
Orenitram <sup>PA</sup>  
Remodulin <sup>PA</sup>  
Revatio <sup>PA</sup>  
Tracleer <sup>PA</sup>  
Tyvaso <sup>PA</sup>  
Uptravi <sup>PA</sup>  
Veletri <sup>PA</sup>  
Ventavis <sup>PA</sup>

### **RSV**

Synagis <sup>PA</sup>

### **Substance abuse treatment**

Vivitrol

### **Transplant**

Astagraf XL  
Atgam  
Cellcept  
Cellcept IV  
Envarsus XR  
Myfortic  
Neoral  
Nulojix <sup>PA</sup>  
Prograf  
Rapamune  
Sandimmune  
Zortress <sup>PA</sup>

## About OptumRx

OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. Our high-quality, integrated services deliver optimal member outcomes, superior savings and outstanding customer service. We are an Optum® company — a leading provider of integrated health services. Learn more at [optum.com](https://www.optum.com).

---

To fill a prescription for a specialty medication on this list, please call **1-855-427-4682** or visit [specialty.optumrx.com](https://specialty.optumrx.com)

---

This specialty pharmacy drug list may not be a complete list of all specialty medications; this list can change at any time without notice.

Non-specialty alternatives may be a recommended first-line therapy to treat your condition. Please consult your doctor.



OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum® company — a leading provider of integrated health services. Learn more at [optum.com/optumrx](https://www.optum.com/optumrx).

All Optum® trademarks are owned by Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are trademarks or registered marks of their respective owners.



# Specialty Prior Authorization

July 28, 2021



# Prior Authorization vs. Step Therapy



## Prior-Authorization

- A review by OptumRx on behalf of your plan to ensure a prescription drug is medically necessary.
- Ensures therapy meets FDA guidelines for the condition being treated.
- Ensures providers follow nationally recognized care criteria when prescribing medication.
- Requires the prescriber to provide documentation in support of the PA criteria prior to medication being dispensed.



## Step Therapy

- Requires a patient try one or more lower cost, preferred medications to treat a health condition.
- Ensures therapy follows cost and clinical guidelines.

# Why Prior Authorization for Specialty Medications?

- Achieves improved quality of member care by using evidence-based criteria to promote appropriate use of certain specialty medications
  - Reduces inappropriate use of high-cost specialty medications



## FIDUCIARY RESPONSIBILITY

Health plans have a responsibility to ensure services provided align with the terms of the plan and are medically necessary.



## SAFETY

Adverse drug events are the most common cause of medicinal harm for patients.



## STANDARD PLAN MANAGEMENT

OptumRx administers Prior Authorization for 55 million members.\*

\*Includes 221K EGWP retirees from the State of New Jersey.  
\*98.4% (60 out of 61) Public Sector clients with coverage for specialty medications have Prior Authorization review.

# Accessibility to the OptumRx Specialty PA Criteria

- ✓ Specialty Prior Authorization criteria will be located on the OptumRx member portal.
- ✓ Retirees will have the ability to access the criteria specific to their specialty medication directly from the member portal at [www.optumrx.com](http://www.optumrx.com) or by calling OptumRx Customer Service.



# Visibility to your Prior Authorization

## Conveniently monitor PAs

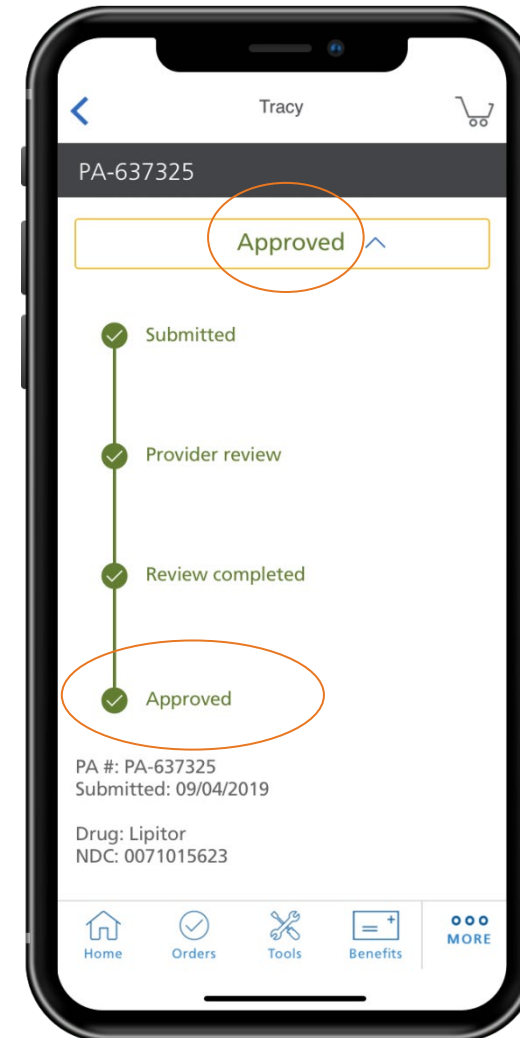
Track a PA status at anytime

## PA alerts eliminate surprises

Members know before they arrive at the pharmacy or need to call their doctor's office and can take immediate action

## Proactive notification

Messages member with immediate actions they can take without having to call customer service



# Prior Authorization

Promoting appropriate and effective medication use

Some medications should be reviewed for coverage because

- They're only approved for, and effective in, treating specific illnesses
- They're high cost and may be prescribed for conditions for which appropriateness and effectiveness have not been well-established

**If left unmanaged without requiring prior authorization, these medications can significantly increase plan costs.**

Example: Xyrem<sup>®</sup>

Annual Cost \$159.6K



**COVERED**  
for narcolepsy

FDA-approved for treating narcolepsy with or without cataplexy



**NOT COVERED**  
for chronic fatigue syndrome or fibromyalgia

Not FDA-approved or sufficient clinical and safety evidence to support use in these conditions

# Prior Authorization Criteria: Xyrem

Product Name: <u>Xyrem</u>	
Diagnosis	Narcolepsy with Cataplexy (Narcolepsy Type 1) [2, 3, A, C, D]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p>1 - Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)</p> <p style="text-align: center;"><b>AND</b></p> <p>2 - Symptoms of cataplexy are present</p> <p style="text-align: center;"><b>AND</b></p> <p>3 - Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present</p> <p style="text-align: center;"><b>AND</b></p> <p>4 - Prescribed by or in consultation with one of the following:</p> <ul style="list-style-type: none"> <li>• Neurologist</li> <li>• Psychiatrist</li> <li>• Sleep Medicine Specialist</li> </ul>	

**References:**

- 1.Xyrem Prescribing Information. Jazz Pharmaceuticals, Inc. Palo Alto, CA. October 2018.
- 2.Morgenthaler TI, Kapur VK, Brown T, et al. Practice parameters for the treatment of narcolepsy and other hypersomnias of central origin: An American Academy of Sleep Medicine report. Sleep. 2007 Dec;30(12):1705-11.
- 3.Wise MS, Arand DL, Auger RR, et al. Treatment of narcolepsy and other hypersomnias of central origin: An American Academy of Sleep Medicine review. Sleep. 2007 Dec;30(12):1712-27.
- 4.International classification of sleep disorders. 3rd ed. Darien, IL: American Academy of Sleep Medicine; 2014.
- 5.Sateia MJ. International classification of sleep disorders - third edition: highlights and modifications. CHEST. 2014 Nov;146(5):1387-1394.
- 6.Scammell TE. Clinical features and diagnosis of narcolepsy. UpToDate Website. March 2017. www.uptodate.com. Accessed October 24, 2018.
- 7.Per clinical consult with neurologist/sleep specialist, October 9, 2012 (confirmed on March 20, 2015).

# Prior Authorization

Promoting appropriate and effective medication use

Example: Humira®

Annual Cost \$114.8K



**COVERED**

for RA, PJIA, PsA, AS,  
CD, UC, Plaque  
Psoriasis, Hydradenitis  
Suppurativa, UV

FDA-approved for treating  
rheumatoid arthritis, polyarticular  
juvenile idiopathic arthritis,  
psoriatic arthritis, ankylosing  
spondylitis, crohn's disease,  
ulcerative colitis, plaque  
psoriasis, hidradenitis  
suppurativa, and uveitis



**NOT COVERED**

for Behcet's Disease,  
Sarcoidosis

Not FDA-approved or  
sufficient clinical and safety  
evidence to support use in  
these conditions



# Prior Authorization Criteria: Humira

Product Name: Humira	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<b>Approval Criteria</b>	
1 - Diagnosis of moderately to severely active RA	
<b>AND</b>	
2 - Prescribed by or in consultation with a rheumatologist	
<b>AND</b>	
3 - Trial and failure, contraindication, or intolerance to one non-biologic disease-modifying antirheumatic drug (DMARD) [e.g., methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)] [2]	

## Trial & Failure:

This criteria is for a patient with a moderately to severely active disease state. Based on nationally accepted treatment guidelines, patients with this diagnosis are started on a conventional treatment regimen until the disease progresses or the conventional treatment is unsuccessful for the patient. The patient then progresses to a biologic as a last line of therapy. Biologics are more aggressive therapies with greater side-effects. This approach is in accordance with the patient selection for clinical trials by the manufacturer and submitted to the FDA for approval of the drug.

# Prior Authorization Criteria: Humira

Product Name: Humira	
Diagnosis	Crohn's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
<p><b>Approval Criteria</b></p> <p><b>1 - Diagnosis of moderately to severely active Crohn's disease [7, 8, B]</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>2 - Trial and failure, contraindication, or intolerance to one of the following conventional therapies: [7]</b></p> <ul style="list-style-type: none"> <li>• 6-mercaptopurine (Purinethol)</li> <li>• azathioprine (Imuran)</li> <li>• corticosteroids (e.g., prednisone, methylprednisolone)</li> <li>• methotrexate (Rheumatrex, Trexall)</li> </ul> <p style="text-align: center;"><b>AND</b></p> <p><b>3 - Prescribed by or in consultation with a gastroenterologist</b></p>	

## References:

1. Humira Prescribing Information. Abbvie Inc. North Chicago, IL. February 2021.
2. Singh JA, Saag KG, Bridges SL Jr, et al. 2015 American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. *Arthritis Care Res.* 2015;68(1):1-25.
3. Ringold S, Angeles-Han ST, Beukelman T, et al. 2019 American College of Rheumatology/Arthritis Foundation guideline for the treatment of juvenile idiopathic arthritis: therapeutic approaches for non-systemic polyarthritis, sacroiliitis, and enthesitis. *Arthritis Rheumatol.* 2019;71(6):846-863.
4. Singh JA, Guyatt G, Ogdie A, et al. 2018 American College of Rheumatology/National Psoriasis Foundation guideline for the treatment of psoriatic arthritis. *Arthritis Rheumatol.* 2019;71(1):5-32.
5. Menter A, Strober BE, Kaplan DH, et al. Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. *J Am Acad Dermatol* 2019;80:1029-72.
6. Ward MM, Deodhar A, Gensler LS, et al. 2019 Update of the American College of Rheumatology/Spondylitis Association of America/spondyloarthritis research and treatment network recommendations for the treatment of ankylosing spondylitis and nonradiographic axial spondyloarthritis. *Arthritis Rheumatol.* 2019;71(10):1599-1613.
7. Lichtenstein GR, Loftus EV, Isaacs KL, et al. ACG clinical guideline: management of Crohn's disease in adults. *Am J Gastroenterol.* 2018;113:481-517.
8. Hanauer SB, Sandborn WJ, Rugeerts P, et al. Human anti-tumor necrosis factor monoclonal antibody (adalimumab) in Crohn's disease: the CLASSIC-I trial. *Gastroenterol.* 2006;130:323-333.
9. Rubin DT, Ananthakrishnan AN, Siegel CA, et al. ACG clinical guideline: ulcerative colitis in adults. *Am J Gastroenterol.* 2019;114:384-413.
10. Feuerstein JD, Isaacs KL, Schneider Y, et al. AGA clinical practice guidelines on the management of moderate to severe ulcerative colitis. *Gastroenterol.* 2020;158:1450-1461.



Richard Ward, FSA, FCA, MAAA  
 West Region Market Director, Public Sector  
 T 956.818.6714  
 M 619.710.9952  
 RWard@Segalco.com

500 North Brand Boulevard  
 Suite 1400  
 Glendale, CA 91203-3338  
 segalco.com

## Memorandum

**To:** Ajay Desai, Director, Division of Retirement and Benefits

**From:** Richard Ward, FSA, FCA, MAAA

**Date:** August 27, 2021

**Re:** OptumRx Retiree Plan Specialty Prior Authorization Program – Focus on Actuarial and Financial Impact for the Retiree Plan - UPDATED

The AlaskaCare Retiree program currently provides coverage for both Pre-Medicare and Medicare Retirees. The Pre-Medicare program is currently being administered through OptumRx. The Medicare Part D (prescription drug coverage) program provides coverage through an Employer Group Waiver Plan (EGWP) administered by OptumRx. Under the EGWP AlaskaCare covers all approved Medicare Part D drugs, plus additional medications through the “wrap” coverage. For approved medications the Plan applies general pharmacy benefit provisions, such as copays, to determine any portion of the costs that are the member’s responsibility. Below is a table outlining the current benefits offered under the Plan:

<b>Deductibles</b>		
Annual individual / family unit deductible	\$150 / up to 3x per family	
<b>Coinsurance</b>		
Most medical expenses	80%	
Most medical expenses after out-of-pocket limit is satisfied	100%	
Second surgical opinions, Preoperative testing, Outpatient testing/surgery (No deductible applies)	100%	
<b>Out-of-Pocket Limit</b>		
Annual individual out-of-pocket limit <ul style="list-style-type: none"> <li>• Applies after the deductible is satisfied</li> <li>• Expenses paid at a coinsurance rate other than 80% do not apply against the out-of-pocket limit</li> </ul>	\$800	
<b>Benefit Maximums</b>		
Individual lifetime maximum (LTM) <ul style="list-style-type: none"> <li>• Prescription drug expenses do not apply against the LTM</li> </ul>	\$2,000,000	
Individual limit per benefit year on substance abuse treatment without precertification. Subject to change every three years	\$12,715	
Individual lifetime maximum on substance abuse treatment without precertification. Subject to change every three years	\$25,430	
<b>Prescription Drugs</b>		Up to 90 Day or 100 Unit Supply
	Generic	Brand Name
Network pharmacy copayment	\$4	\$8
Mail order copayment	\$0	\$0

A change is currently being considered to add additional oversight to specialty medications for members with coverage in the EGWP and non-EGWP plans. Specialty medications continue to be a growing portion of a program's pharmacy spend. While these medications can be highly effective, they also represent some of the most costly medications on the market. Additionally, specialty medications may be more or less effective for certain members, and in an effort to ensure the right individuals receive these medications, many plans have implemented evidenced-based guidelines for approval. These guidelines can help promote safe and effective use of specialty medications, while mitigating the potential for waste in a high dollar medication category.

The OptumRx Specialty Prior Authorization program would implement evidenced-based review aspects before specialty medications are dispensed. These specialty medications would be reviewed for the specific therapeutic benefit, dosage recommended, and effectiveness given the retiree's need(s) and/or other potential medication usage. OptumRx will then render a clinical coverage determination for the specific drug and dosage under review.

## Actuarial Value

The Department of Administration is considering implementing a prior authorization program to help manage specialty medications. While this program does introduce changes that promote safe and effective usage of specialty medications to help manage costs, it does not impact the retiree's cost for that medication. This change also does not remove any drugs currently being covered by AlaskaCare. Due to these factors implementation of this program would not impact the actuarial value.

## Financial Impact

Based on the most recent retiree medical and pharmacy claims projection of \$617,000,000 for 2022, the projected financial impact for 2022 pharmacy claims would be a reduction of roughly \$7,700,000 (or 1.2% of total projected costs).

OptumRx performed initial analysis on the impact to claims costs, rebates and EGWP subsidies, which were then refined by Segal. The primary refinement was to adjust for the OptumRx analysis being based on general market and book-of-business data and assumptions. The Segal analysis accounts for prescribing and utilization patterns in the AlaskaCare program.

Projected claims savings are due primarily to the PA program resulting in more clinically appropriate drugs being prescribed, as well as some reviews resulting in no medications being dispensed. These projections assume that more than 90% of retirees taking medications on the PA drug list will be approved.

Implementing the PA program will affect drug manufacturer rebates. Changes in the prescribed medication may change the rebate associated with the prescription, but the introduction of utilization management also enables OptumRx to access more favorable rebate terms in some manufacturer contracts. These increased rebates are available regardless of whether or not the PA review results in a change in the medication.

For both the EGWP and the non-EGWP plans, this is primarily driven by medications in the anti-inflammatory class. The expected increase in rebates from these enhanced contract terms will more than offset any decreases in rebates from PA reviews that change the initial prescription.

The chart below provides a breakout of the total projected savings in detail:

	<b>Non-EGWP</b>	<b>EGWP</b>	<b>Total</b>
2022 Claims Savings*	\$1,400,000	\$3,100,000	\$4,500,000
2022 Rebates Changes**	\$3,600,000	\$1,600,000	\$5,200,000
2022 EGWP Changes	N/A	-\$2,000,000	-\$2,000,000
<b>Total Savings</b>	<b>\$5,000,000</b>	<b>\$2,700,000</b>	<b>\$7,700,000</b>

\* Claims savings are net of anticipated costs to administer the PA program, which are estimated to be approximately \$40,000-\$50,000 annually for the non-EGWP plans and approximately \$70,000 to \$90,000 annually for the EGWP plans.

\*\* The change in earned rebates is shown and should be a reasonable indication of the annual impact over the long term. However, should there be a shortfall in the actual rebates compared to the levels guaranteed by OptumRx, then these amounts would be offset by the shortfall.

## Additional Notes

The data used for this analysis was reviewed, but not audited, and found to be sufficient and credible.

The above projection is an estimate of future cost and is based on information available to Segal at the time the projection was made. Segal has not audited the information provided. A projection is not a guarantee of future results. Actual experience may differ due to, but not limited to, such variables as changes in the regulatory environment, local market pressure, change in demographics, overall inflation rates and claims volatility. Projection of retiree costs takes into account only the dollar value of providing benefits for current retirees during the period referred to in the projection. It does not reflect the present value of any future retiree benefits for active, disabled, or terminated employees during a period other than that which is referred to in the projection, nor does it reflect any anticipated increase in the number of those eligible for retiree benefits, or any changes that may occur in the nature of benefits over time.

The Coronavirus (COVID-19) pandemic is rapidly evolving and will likely impact the 2021 US economy and health plan claims projections for most Health Plan Sponsors. As a result, projections could be significantly altered by emerging events. At this point, it is unclear what the impact will be for Health Plan Sponsors. Segal continues to develop and review plan cost adjustment factors and reports to apply to both short-term and long-term financial projections. Additionally, the potential for federal or state fiscal relief is also not contemplated in these budget projections.

cc: Emily Ricci, Division of Retirement and Benefits  
Betsy Wood, Division of Retirement and Benefits  
Andrea Mueca, Division of Retirement and Benefits  
Noel Cruse, Segal  
Kautook Vyas, Segal  
Amy Jimenez, Segal  
Eric Miller, Segal  
Quentin Gunn, Segal